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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 06/21/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Eighty additional hours of a chronic pain management program

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Eighty additional hours of a chronic pain management program - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the right knee interpreted by M.D. dated 04/01/09 and 05/17/10
Evaluations with an unknown provider (no name or signature was available) dated 04/30/09, 05/11/09, 05/21/09, 06/04/09, 05/17/10, 08/06/10, 10/16/10, 11/14/10, and 12/23/10

An MRI of the right knee interpreted by Dr. on 05/02/09

An MRI of the left knee interpreted by Dr. dated 05/07/09

X-rays of the lower spine interpreted by Dr. dated 06/04/09

Evaluations with M.D. dated 07/17/09, 08/12/10, and 09/21/10

An operative report from Dr. dated 09/09/09

An MRI of the lumbar spine interpreted by Dr. dated 01/06/10

Evaluations with P.A. dated 02/18/10 and 06/04/10

Evaluations with M.D. dated 03/15/10 and 05/13/10

A Designated Doctor Evaluation with M.D. dated 05/25/10
A DWC-73 form from Dr. dated 05/25/10
An evaluation with M.D. dated 11/09/10
An evaluation with M.D. dated 12/23/10
A Physical Performance Evaluation (PPE) with an unknown provider (signature was illegible) dated 01/18/11
Psychological evaluations with L.P.C. dated 01/18/11 and 04/11/11
A medication contract dated 01/24/11
A precertification request from L.P.C. dated 01/25/11
Evaluations with D.O. dated 02/09/11, 02/17/11, 03/02/11, 03/16/11, 03/24/11, 03/31/11, 04/06/11, 04/20/11, 05/18/11, 05/25/11, and 06/01/11
Group therapy with Mr. dated 04/06/11
Chronic pain management with an unknown provider (signature was illegible) dated 04/07/11 and 04/14/11
A letter of non-certification for 80 additional hours of chronic pain management, according to the Official Disability Guidelines (ODG) from D.C. dated 04/15/11
A request for an appeal from Dr., Mr., and D.C. dated 04/22/11
A letter of non-certification for 80 additional hours of chronic pain management, according to the ODG, from D.C. dated 05/06/11
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

X-rays of the right knee interpreted by Dr. on 04/01/09 were unremarkable. An MRI of the right knee interpreted by Dr. on 05/02/09 showed a vertical bucket handle tear in the posterior horn of the medial meniscus with moderate degenerative joint disease. An MRI of the left knee interpreted by Dr. on 05/07/09 showed a horizontal non-displaced tear of the posterior horn of the medial meniscus with moderate degenerative joint disease. On 05/11/09, an unknown provider recommended physical therapy, Skelaxin, and an orthopedic evaluation. X-rays of the lower spine interpreted by Dr. on 06/04/09 showed degenerative changes of the lumbar spine. Right knee surgery was performed by Dr. on 09/09/09. An MRI of the lumbar spine interpreted by Dr. on 01/06/10 showed L5-S1 greater than L4-L5 central disc protrusions with impingement of the traversing L4 and L5 nerve roots bilaterally. On 05/13/10, Dr. recommended a lumbar translaminar epidural steroid injection (ESI) at L5-S1, trigger point injections, and continued Norco. On 05/25/10, Dr. placed the patient at clinical Maximum Medical Improvement (MMI) with a 6% whole person impairment rating. On 06/04/10, Mr. prescribed Ambien and performed a steroid injection of the knee. A PPE with an unknown provider on 01/18/11 showed the patient could use a chronic pain management program and a psychological evaluation. On 01/18/11, Mr. recommended 20 sessions of a chronic pain management program. On 02/17/11, Dr. wanted to reduce the Tramadol. On 03/16/11, Dr. noted good progress in the chronic pain management program. On 04/11/11, Mr. wrote a precertification request for eight more sessions of chronic pain management. On 04/15/11, Dr. wrote a letter of adverse determination for the additional pain management sessions. On 05/06/11, Dr. also wrote a letter of adverse determination for the additional pain management sessions. On 06/01/11, Dr. refilled Tramadol, Hydrocodone, and Paxil.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) states that treatment in a chronic pain management program is not suggested for longer than two weeks without evidence of compliance and significant, demonstrated efficacy. Furthermore, the ODG states that treatment in excess of 160 hours requires a clear rationale for the specified extension and the goals to be achieved. Given the significant amount of chronic pain management that has already been provided to the patient, the continued use of pain medications, the minimal improvement as seen by her VAS scores, and her continued pain levels of 7-8/10, it seems highly medically unlikely that an additional 80 hours of chronic pain management will be effective, substantially change or limit the amount of her pain, or increase her functionality. Therefore, the requested additional 80 hours of a chronic pain management program is not reasonable or necessary and the previous adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES

- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)