Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/03/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5 x Week x 2 Weeks

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

Board Certified in Physical Medicine and Rehabilitation

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.

Chronic Pain Management Program 5 x Week x 2 Weeks – OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 12/10/09

- Progress Notes, P.A.C., 12/21/09
- Patient Review Past Note, M.D., 01/08/10
- Patient Review Past Note, M.D., 02/04/10
- Progress Notes, Medical Clinic, 04/21/10
- Designated Doctor Report, M.D., 05/06/10, 10/07/10, 03/28/11
- Initial Evaluation, D.C., 09/30/10
- Initial Orthopedic Consultation, M.D., 10/12/10
- Medical Evaluation, M.D., 11/11/10
- Subsequent Medical Report, Dr. 11/16/10
- Correspondence, Dr. 11/30/10
- Request for Services, 01/14/11
- Functional Capacity Evaluation, Clinic, Inc., 01/28/11
- New Patient Evaluation, M.D., 02/01/11
- Pre-Authorization Intake Form, 02/17/11
- Request for a Chronic Pain Management Program, 02/17/11
- Denial Letter, 02/23/11, 03/15/11
- Request for a Medical Dispute Resolution, 04/14/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured when she experienced pain in the lumbar region. An MRI of the lumbar spine showed a small broad-based posterior disc protrusion at L4-L5 with mild central canal stenosis secondary to a congenitally narrow canal with ligamentum flavum hypertrophy. There was a small posterior central disc protrusion at L5-S1 with no canal stenosis. There was minimal bulging of the L3-L4 intervertebral disc. Epidural steroid injection (ESI) has been performed. The patient has completed physical therapy and psychotherapy sessions. She was making minimal progress, due to poor coping skills, anxiety, depression and pain complaints. She has been suffering from anxiety, depression, muscular tension and has since developed chronic pain symptoms and not returned to work.

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

The chronic pain management program as presented by the treating physician does appear to be medically reasonable and necessary. Based on my review of the above listed clinical records, and review of the ODG criteria for the use of chronic pain management programs, it does appear that the patient has met the appropriate applicable criteria.

The criteria for the general use of multidisciplinary pain management indicates that the patient should have a chronic pain syndrome with the pain that persists beyond three months, including *three or more of the following*: (a) the use of prescription drugs beyond a recommended duration or abuse of or dependence on prescription drugs or substances; (b) excessive dependence on healthcare providers, spouse, or family; (c)

secondary physical deconditioning due to disuse or fear avoidance of physical activity due to pain; (d) withdrawal from social knowhow including work, recreation, or other social contact; (e) failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) development of psychosocial sequelae after the initial incident including anxiety, fear avoidance, depression, or nonorganic illness behavior; (g) the diagnosis is not primarily a personality disorder or psychological condition without a physical condition. Also, criteria includes the patient having significant loss of the ability to function independently resulting from the chronic pain, and previous methods of treating the chronic pain have been unsuccessful, and there is an absence of other options likely to resolve in significant clinical improvement.

This patient does appear to suffer from a chronic pain syndrome and multiple records clearly reveal evidence that ODG criteria for entrance into a pain management program per above has been met. Therefore, it is my medical opinion that the request for chronic pain management program is indeed reasonable and necessary.

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 UM KNOWLEDGEBASE**
- ☐ **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**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **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)**
- ☐ **AMA GUIDES 5TH EDITION**