

Notice of Independent Review Decision

DATE OF REVIEW: 09/14/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5xWk x 2Wks 80 Hours

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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.

Based on the above medical records and in keeping with the ODG treatment guidelines upon which the request was based, it is my opinion that the original denials for chronic pain management program, ten sessions, 80 hours, be upheld as a denial.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 17 page fax 08/25/11 IRO request, 45 page fax 08/25/11 URA response to disputed services including administrative and medical, 53

The DYLL REVIEW

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page fax 08/25/11 Provider response to disputed services including administrative and medical. Dates of documents range from 6/09/10 to 08/25/11

- Medical records from M.D., dated 07/19/11, 08/02/11, and 08/09/11.
- Medical records from D.O., for dates 10/25/10, 10/20/10, 10/07/10, 09/01/10, 07/20/10, 06/09/10, 10/25/10, 11/17/10. Also, 01/18/11, 03/01/11, 06/01/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained a sprain/strain of the lumbar spine, was identified with preexisting degenerative disk disease for which he underwent a two-level lumbar fusion at L4-5 and L5-S1 xx/xxxx. He does not appear to have undergone any organized, systematic, post-surgery rehabilitation and was released to return to work at a sedentary to light duty. The records reflect that his preinjury work was a very heavy type of work, but post surgery, not being able to return to this level of activity, he then has sought light-duty employment. His current medication list is noted to be minimal. He remains with symptomatic reports of pain but no significant objective orthopedic or neurologic deficits.

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

Review of the submitted medical information indicates that this man sustained a sprain/strain of the lumbar spine, was identified with preexisting degenerative disk disease for which he underwent a two-level lumbar fusion at L4-5 and L5-S1 xx/xxxx. He does not appear to have undergone any organized, systematic, post-surgery rehabilitation and was released to return to work at a sedentary to light duty. The records reflect that his preinjury work was a very heavy type of work, but post surgery, not being able to return to this level of activity, he then has sought light-duty employment. His current medication list is noted to be minimal. He remains with symptomatic reports of pain but no significant objective orthopedic or neurologic deficits. There are questions concerning whether he may be experiencing hardware-type pain for which additional surgery may be required. At this point in time, lacking a lower level of therapeutic care for his symptoms, and with the question of possible need for additional surgery, the request for initial chronic pain management program is not supported by the ODG.

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)**