

C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x80 Hours

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

M.D., Board Certified Pain Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Employer's first report of injury or illness dated xx/xx/xx

Worker's compensation request for medical care dated 07/29/11

Emergency department records dated 07/29/11

Bona fide job offer dated 08/01/11

Clinic note ETMC First Physicians dated 08/15/11

Healthcare and rehabilitation records dated 08/18/11-04/16/12

MRI lumbar spine without contrast dated 09/06/11

Initial consultation and follow-up notes M.D. dated 09/07/11-04/13/12

Electrodiagnostic testing dated 09/20/11

Letter of medical necessity dated 10/01/11

Clinical records Spine Solutions 10/07/11

Clinical observation / comments dated 12/14/11 L.M.S.W.

Functional capacity evaluation dated 01/05/12

Report of medical evaluation / MMI report / Impairment rating dated 01/12/12

Therapy session notes 2-6 dated 01/10/12-02/23/12

Procedure note dated 02/10/12

Physical performance exam dated 03/01/12

Procedure note dated 03/16/12

Procedure note dated 03/30/12

Physical performance exam dated 04/05/12

Request for authorization dated 04/20/12

Utilization review determination dated 04/25/12

Reconsideration request dated 04/30/12

Utilization reconsideration review dated 05/07/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a woman who injured her back on xx/xx/xx while pulling frozen food cases and putting them into boxes because the cooler went out. The patient was seen and diagnosed with a lumbar sprain/strain. She has had physical therapy, MRI lumbar spine dated 09/06/11(1-2 mm bulge at L5-S1), EMG/NCV dated 09/20/11 (within normal limits), bilateral medial branch blocks L4 and L5 on 02/10/12 (100% relief for 24 hours), left lumbosacral facet rhizotomy at L4 and L5 on 03/16/12, right lumbosacral facet rhizotomy at L4 and L5 on 03/30/12, individual psychotherapy and medication management. Functional capacity evaluation dated 01/05/12 indicates that current PDL is below sedentary and required PDL is medium. MMI report dated 01/12/12 indicates that the patient has not reached MMI. PPE dated 03/01/12 indicates that current PDL is sedentary. PPE dated 04/05/12 indicates that current PDL is sedentary.

Current medications are Hydrocodone and Gabapentin. Psychological evaluation dated 04/20/12 indicates that BDI is 22 and BAI is 23. Diagnoses are adjustment disorder with mixed anxiety and depressed mood; pain disorder associated with both psychological factors and a general medical condition, chronic.

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

The patient has been diagnosed with a lumbar sprain/strain, which should have resolved at this time. The patient's diagnostic testing is normal, and the patient's subjective complaints outweigh any objective findings. The patient has undergone extensive treatment to date without any significant benefit and has now been referred to a chronic pain management program directed and administered by the same facility and providers who have been directing her unsuccessful care to date. The reviewer finds that Chronic Pain Management Program x 80 Hours is not medically necessary.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)