

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management

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

PM&R; 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 06/22/09-04/16/13

Previous utilization review determinations dated 03/27/13 and 04/19/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who reported an injury regarding his low back. The clinical note dated 06/22/09 details the claimant complaining of low back pain. The patient was noted to have been injured on xx/xx/xx and noted to have trouble with the low back. The note details the patient having undergone a fusion at L4-S1 in 08/04 without significant changes. The patient was recommended for surgical intervention at that time with no completion of surgery. The patient was noted to have undergone 3-4 epidural steroid injections each year over 3 year period with minimal benefit. The clinical note dated 02/07/13 details the patient able to demonstrate 14 degrees of lumbar flexion, 25 degrees of extension, 11 degrees of left lateral flexion, and 12 degrees of left lateral flexion. Clinical note dated 03/05/13 details the patient stating initial injury occurred on 04/11/02 when he was moving refrigerator downstairs. The patient was initially placed on light duty but overwhelmed with severe pain. The note details the patient having previously undergone physical therapy, injection therapy, spinal cord stimulator, TENS unit, or chronic therapy as well as previous surgery. The note details the patient having undergone psychological evaluations where he scored 20 on BDI-II and 2 on BAI revealing moderate depressive symptomatology and minimal anxiety. The patient rated pain at that time as 7/10.

The previous utilization review dated 03/27/13 details the patient's request for chronic pain management program being denied secondary to the patient's date of injury being greater than xx years ago.

The utilization review dated 04/19/13 resulted in denial for chronic pain management program secondary to the patient's date of injury being outside 24 month window.

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

The documentation details the patient complaining of ongoing low back pain. The Official Disability Guidelines recommend inclusion into chronic pain management program provided the patient meets specific criteria to include provided the patient has not been continuously disabled for greater than 24 months. The documentation details the patient's date of injury of being greater than xx years of age. Given significant findings indicating the patient's date of injury being outside 24 month window, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for 80 hours of chronic pain management is not indicated as 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 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)