

DATE OF REVIEW: 8/29/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twenty (20) chronic pain management sessions.

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

This case was reviewed by a board certified psychiatrist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS/ NDC</i>	<i>Units</i>	<i>Begin/End Date</i>	<i>Type Review</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
739.3	97799	20	7/24/07-7/27/07	Prospective				Upheld
739.9	97799	20	7/17/07-7/20/07	Prospective				Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 8/8/07
2. Determination Notices – 7/20/07, 7/27/07
3. Records and Correspondence– 2/22/07-7/24/07
4. Records and Correspondence from DO – 7/10/07
5. Records and Correspondence from MRI – 12/29/06, 3/16/07, 3/26/07
6. Records and Correspondence– 12/7/06-6/1/07
7. Records and Correspondence from Associates – 1/8/07
8. Records and Correspondence from Clinic – 6/26/07

9. Records and Correspondence from DC – 12/27/06
10. Records and Correspondence from Hospital
11. Records and Correspondence from MD – 2/23/07, 6/1/07
12. Records and Correspondence from MD – 3/26/07
13. Functional Abilities Evaluation – 7/10/07
14. Records and Correspondence from MD – 7/26/07

PATIENT CLINICAL HISTORY:

This case concerns an adult female who sustained a work related injury. Records indicate the member sustained injury when she slipped on steps and fell backward landing on her buttock and then twisting her left knee. Diagnoses have included lumbar nerve root injury, lumbar radiculopathy, hip derangement, pain disorder, major depressive disorder, nonallopathic lesions of the lumbar region, injury to lumbar root and knee meniscal tear. Evaluation and treatment for this injury has included chiropractic treatment, MRIs, x-rays and medications.

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

The Official Disability Guidelines (ODG) state that chronic pain management (CPM) programs are indicated for patients for whom previous methods of treating the pain have been unsuccessful. While the pain has been measured at 5/10, adjunctive symptoms which would have been addressed by the program have decreased markedly, most notably the services on the Beck Anxiety Inventory (BAI) & Beck Depression Inventory (BDI). The patient has only had 6 psychotherapy sessions and according to a note dated 7/10/07, she has made progress and refused the recommended treatment of steroid injection and sacrococcygeal nerve block. She is not on psychotropic medications. The data reviewed in sum do not indicate that previous treatment methods have been unsuccessful and hence the ODG guidelines are not met. Therefore, the requested twenty (20) chronic pain management sessions are not medically necessary for treatment of the patient's condition at this time.

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)