



DATE OF REVIEW: 6/26/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for the previously denied 10 days of Chronic Behavioral Pain Management Program.

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

Texas licensed.

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)
- The previously denied request for 10 days of Chronic Behavioral Pain Management Program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Request Letter dated 6/20/07.
- Notice to CompPartners, INC. of Case Assignment dated 6/18/07.
- Fax Cover Sheet dated 6/18/07.
- Utilization Review Request dated 5/2/07, 4/2/07.
- Request for a Review by an Independent Review Organization dated 5/22/07.
- Utilization Review Agent dated 5/31/07.
- Denial Information dated (unspecified).
- Workers' Compensation (WC) Health Care Network Information dated (unspecified).
- Additional Physicians or Health Care Providers dated (unspecified).
- Name of Party Requesting IRO dated (unspecified).
- Form for Requesting a Review by an Independent Review Organization (IRO) dated (unspecified).
- Providers Information dated (unspecified).

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient's age:

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of injury:

Diagnoses: Cervicalgia; sprains and strains of the left shoulder.

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

A review of the information provided indicated that this female sustained a work-related injury involving the shoulder and neck on xx/xx/xx, secondary to lifting some heavy trash bags. Working diagnoses includes cervicalgia and sprain/strain of left shoulder. Of note, this injury. Subsequent to the claimant's injury, she was treated with conservative treatment consisting of rest, chiropractic manipulation, TENS unit, physical therapy, medication management, and interventional pain management injections. Diagnostic testing performed request submitted for this review include X-rays, MRIs, electromyogram/nerve conduction velocity (EMG/NCV) studies, and physical evaluation reports to include functional capacity evaluation (FCE). The psychological testing revealed that this claimant also suffered from significant anxiety and showed clinical features of reactive depression, reportedly even after individual psychotherapy sessions. Current medication management consists of Paxil, Valium, Percocet (usage not specified), and Lunesta. The requesting provider is recommending pain management program to provide this patient with slow stabilization, improved sleep, and increased utilization of pain management skills. Of note, this patient has not worked in years. The main purpose of chronic pain management programs is to return a patient back to work. This success is reduced drastically after, and this injury is over. There is no peer review literature to support programs for these older injuries. The clinical indication and necessity of the request could not be established.

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

X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.

ACOEM Guidelines, 2nd Edition, Chapter 6.

- 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

**Official Disability Guidelines, Treatment Index, 5th Edition,
2006/2007 Under Pain Section – Chronic Pain Programs.**

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
