
DATE OF REVIEW: MARCH 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions Chronic Pain Management Program

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

MD, Board Certified in Family Practice

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letters from
- Notes from
- Clinical notes from Dr., DC
- Progress notes from Dr.
- MRI L-5 spine 10/10/06
- Dr. consultation 10/13/06
- Dr. Designated Doctor Exam 11/17/06
- RME per Dr. on 11/23/06
- TDI paperwork
- South records
- TWCC 73 form
- MES Solutions per Dr. peer review on 1/30/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained a work related injury . Patient received a myriad of treatments including restricted duty, physical therapy, chiropractic care, medications, psychotherapy, biofeedback, and home exercise program. She apparently developed anxiety and depression from her injuries. A request for CPM was denied and an appeal was requested that upheld the denial.

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

THIS PATIENT INCURRED INJURIES AND, UNFORTUNATELY, STILL HAD SIGNIFICANT SYMPTOMOLOGY THROUGH FEBRUARY, 2007 AFTER MULTIPLE MODALITIES OF CONSERVATIVE THERAPY. THE SUBMITTED RECORDS SUGGEST EXHAUSTIVE TREATMENTS WERE EMPLOYED. EACH MODALITY IN A COMPREHENSIVE PAIN MANAGEMENT PROGRAM HAS VIRTUALLY ALREADY BEEN UNDERTAKEN. THEREFORE, NO JUSTIFICATION OR MEDICAL NECESSITY CAN BE DERIVED FROM THE INFORMATION SUBMITTED. THIS VIEWPOINT IS SUPPORTED BY STANDARD TEXTBOOKS, PEER REVIEWED LITERATURE, AND GENERALLY ACCEPTED GUIDELINES.

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
* CMS GUIDELINES
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)