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Notice of Independent Review Decision

**DATE OF REVIEW: 10/9/07****IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic Pain Management – 20 sessions (97799)

**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>
506.	97799		8/7/07-10/7/07	Prospective				Overturned
784.0	97799		8/17/07-10/31/07	Prospective				Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 9/19/07.
2. Determination Notices – 8/10/07 and 8/24/07.
3. Records and Correspondence from Medical Center – 11/13/06-9/15/07.
4. Records and Correspondence from Medical Group – 9/13/07.
5. Records and Correspondence from, MD – 10/20/06.

6. Records and Correspondence from, MD – 7/12/07.
7. Preauthorization Request Form from, MD – 8/6/07.
8. Reconsideration Request Form from, MD – 8/15/07.

**PATIENT CLINICAL HISTORY:**

This case concerns an adult male who sustained a work related injury on xx/xx/xx. Records indicate the member was walking in the plant and began to smell an odor. He experienced a burning sensation in his nose, throat and mouth and started coughing heavily resulting in vomiting. He also became dizzy. Diagnoses have included chemical inhalation, headache, dizziness, coughing, depression, and anxiety. Evaluation and treatment for this injury has included x-rays, CT scans, ultrasound, physical therapy, breathing treatments, medications, and psychotherapy.

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

In his preauthorization request dated 8/6/07, the member's treating physician (MD) makes a strong case for approval of 20 sessions of chronic pain management program. In his reconsideration request of 8/15/07, he supports re-diagnosis of the patient's condition as "chronic pain syndrome". In DSMIV terminology, this corresponds to "pain disorder associated with both psychological factors and a general medical condition". The evaluation does show criteria are met. The multi-disciplinary treatment approach outlined is appropriate and meets Official Disability Guidelines medical necessity criteria. Therefore, the requested Chronic Pain Management – 20 sessions (97799) is medically indicated for treatment of the patient's condition.

**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 TCADA 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)**