



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 12/07/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic pain management five times a week times two weeks.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C. for sixteen years, currently practicing in a multidisciplinary clinic, emphasizing pain management and rehabilitation.

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

I find that medical necessity for this program has been met for chronic pain management five times a week times two weeks, and the previous adverse determination is overturned.

**INFORMATION PROVIDED FOR REVIEW:**

1. 11/17/08, TDI fax cover to Forensics from, two pages
2. 11/17/08, The Utilization Review Department to TDI, one page
3. 11/17/08, TDI confirmation of receipt of a request for review by IRO, one page
4. 11/17/08, company request for IRO, seven pages
5. 11/03/08, The noncertification of request for chronic pain management, five times two, M.D., four pages
6. Undated, The noncertification notification of request for CPM based on Peer Review of 11/08/08, D.C., D.A.V.C.O., D.A.V.C.C., D.A.V. Q.A.U.R.P., six pages
7. 11/17/08, notice to Forensics of case assignment, one page
8. 11/18/08, request for medical dispute resolution, Trust, , Ph.D., two pages
9. 10/24/08, behavioral evaluation, Ph.D., L.P.C.-S., Q.M.H.P., eleven pages

10. 10/03/08, Injury Center of, patient re-evaluation, D.C., two pages
11. 09/08/08, Ambulatory Surgery Center, operative report, two pages
12. 08/08/08, Pain Consultants Association, M.D., one page
13. 10/29/08, Trust request for CPM, fifteen pages
14. 11/04/08, Trust reconsideration for request for CPM, eighteen pages

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee suffered a work injury while working as an xxxx when driving down a steep slope, and his truck turned over. He felt pain in the right shoulder and the right side of the body. He underwent injections, physical therapy, chiropractic care, surgery, medications, work hardening, and individual counseling. Chronic pain management was recommended but denied by two Peer Reviewers.

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

This patient has completed all lower levels of care. He has satisfied the ODG requirements, and based on my own clinical practice, is a suitable candidate for chronic pain management. Necessary treatment plan and goals have been established. The service is considered reasonable and necessary.

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

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)