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Notice of Independent Review Decision

DATE OF REVIEW: February 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program x 20 days

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

Diplomate, American Board of Anesthesiology; Diplomate, American Academy of Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the URA include:

- Official Disability Guidelines, 2007

- Pain Management, 07/27/07, 08/03/07, 08/07/07, 08/22/07
- Clinic, 08/01/07
- 08/15/07, 09/04/07
- Clinic, 08/03/07

Medical records from the Provider include:

- 06/19/07

PATIENT CLINICAL HISTORY:

This is a female who sustained a work related injury involving the cervical/thoracic/lumbar spine secondary to performing repetitive-type movements for a long period of time. The current diagnoses: 1) Cervical sprain/strain. 2) Lumbar sprain/strain. 3) Thoracic sprain/strain. 4) Chronic pain behavior.

The patient currently rates her pain score on a scale of 0-10 at an 8/10. The patient indicates that she has significant fatigue and weakness within her body, especially at the areas of pain. The patient reports major relaxation difficulty, as well as significant irritability and mood problems.

The current medication management consists of Naprosyn, Darvocet, and Tramadol (dosage/usage for all three medications is not documented). Of note, there were no diagnostic tests submitted related to the anatomical areas of pain involved.

Previous treatments identified include nerve blocks, TENS unit, manipulation, heat therapy, bedrest, massage, ultrasound, exercise, and four psychotherapy sessions. Of note, the patient reportedly has received benefit from the psychotherapy sessions in terms of mood management. However, these sessions are not able to meet her overall pain management needs reportedly as it pertains to active rehabilitation in a biopsychosocial treatment manner.

It appears from behavioral testing performed on August 3, 2007 that the patient experiences anxiety and depression. The treating physician has requested chronic pain management program x 20 sessions to help improve the patient's function and her disability with a return back to the workforce.

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

After review of the information submitted, the previous denial for a chronic pain management program is upheld.

It is opinion of this reviewer that there does not appear to be any valid objective reason for this patient's ongoing pain complaints. The patient reports to have depression/anxiety associated with this injury. Nowhere in the medical records do I find any thing more than an evaluation by a psychologist. There is no monitoring of the patient's depression or anxiety. There are no medications prescribed for the patient's above psychosocial issues.

In addition, the main purpose of a chronic pain program is to return the patient back to work of which the success is reduced drastically after one year. There is no peer review literature to support programs for these older injuries.

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)**