Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 01/23/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Ten days of a chronic pain management program.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management for 22 years.

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

__X___Upheld (Agree)

_____ Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial 11/09/07 & 12/03/07, and UM evaluation 11/09/07, including criteria used in denial.
3. Pain management evaluation & PPE 10/17/07
4. Patient status update to URA 11/06/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This patient was injured and had a herniated disc with nerve impingement. Physical examination and chiropractic care have been performed. He has returned to work in a light duty position. An Functional Capacity Evaluation shows that he is capable of light duty.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
The ODG criteria are:

1. *An adequate and thorough evaluation has been made including baseline functional testing.* Opinion: The evaluation was cursory, and the usual psychological instruments such as the MMPI-II have not been utilized. This criteria has not been met.

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2. *Previous methods of treating the chronic pain had been unsuccessful*. Opinion: This criteria has been met.
3. *The patient has a significant loss of ability to function independently, resulting in chronic pain*. Opinion: This individual is employed in a light duty situation and is functioning well. This criteria has not been met.
4. *The patient is not a candidate where surgery could clearly be warranted*. Opinion: The patient has evidence of nerve impingement, and therefore, surgery remains an option. This criteria has not been met.
5. *The patient exhibits motivational changes and is willing to forego secondary gains including disability and pain to effect this change*. Opinion: This individual is employed, and there are no disability payments involved. This criteria has not been met.
6. *Predictors of success have been addressed*. Opinion: It is unclear whether this has been addressed.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THIS 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.
__X __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.)

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