

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** March 17, 2008

**IRO CASE #:**

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

Chronic pain management x 20 days (CPT 97799)

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

General and Forensic Psychiatrist; Board Certified by the American Board of Psychiatry and Neurology

**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 Provider include:

- Injury Clinic, 09/26/07, 01/07/08, 01/30/08, 02/18/08, 02/19/08, 02/22/08, 02/25/08, 03/04/08, 03/11/08
- 12/21/07
- D.O., 02/13/08
- 02/22/08, 03/05/08

Medical records from the URA include:

- Official Disability Guidelines, 2007
- Injury Clinic, 09/26/07, 01/07/08, 01/30/08, 02/18/08, 02/19/08, 02/25/08
- 12/21/07
- D.O., 02/13/08
- 02/22/08, 03/05/08

### **PATIENT CLINICAL HISTORY:**

The patient had a fall on xx/xx/xx, resulting in injury to her lower back and leg. She apparently was referred for physical therapy, which she did not fully complete initially.

The patient underwent conservative treatment and changed her treating physician to D.O., who referred her for a behavioral health evaluation that was accomplished on September 26, 2007. During that evaluation, some pertinent history is noted including that she did not complete the initial physical therapy referral. Her Beck Depression Inventory is scored at a 20. Her Beck Anxiety Inventory is scored at a 28. They note a prior prescription for Zoloft, however, there is not any detailed support regarding why this was prescribed or her response to this medication. Her diagnosis was major depressive disorder, moderate. She was recommended to participate in individual psychotherapy.

There is a subsequent evaluation by, M.D., on December 21, 2007, which includes a history that the patient is currently on disability for asthma and diabetes. His examination of the patient demonstrated probable nonphysiologic behaviors.

On January 7, 2008, there is a treatment goal plan for a chronic pain management program submitted.

On January 30, 2008, there is a functional capacity examination for which the patient could not perform most of the elements of the examination and for which there was a significantly reduced grip and pinch strength, however, no explanation of how this fit in with the injury of her lower back and leg.

The request for a chronic pain management program was not authorized due to the rationale of there being an inadequate initial assessment.

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

I concur with the denial of the chronic pain management program as the submitted material does not substantiate the medical necessity of the proposed treatment according to the ODG, under Criteria For The General Use Of Multidisciplinary Pain Management Program: 1) An adequate and thorough evaluation has been made including baseline functional testing, therefore, a followup with the same tests can note functional improvement. 5) The patient exhibits motivation to change and is willing to forego secondary gains including disability payments to effect this change. 6) The negative predictors of success above have been addressed.

The submitted material does not include baseline functional testing since the primary initial evaluation prior to the request for individual psychotherapy does not address the nonphysiologic behaviors noted in other physical examinations, nor does it address adequately the prior mental health history treatment with Zoloft. It does not address the motivation of the patient who is already on disability for other conditions, nor does it address the negative predictors of success.

Finally, the treatment plan is extensive, however, it does not appear to be specific to this patient, whether or not there are warranted objective goals included in the planning, or timelines for improvement expected.

**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)