

Notice of Independent Review Decision

**DATE OF REVIEW:** 10/13/08

**IRO CASE #:**

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

Ten sessions of outpatient 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 full-time practice of Pain Management since the early 90's

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
	97799	NA	Prosp.						Upheld

**INFORMATION PROVIDED FOR REVIEW:**

- TDI case assignment
- Letters of denial 08/01/08 & 08/21/08, including criteria used in the denial (ODG)
- Physical performance exam 07/29/08
- Pain management evaluations, treatment goals and progress notes 10/09/07 – 08/14/08

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

This individual has neck and back pain after sustaining a work-related injury in xx/xx. She has not responded to medications, physical therapy, chiropractor care, and six sessions of individual psychotherapy. Surgery has been recommended.

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

The ODG Guidelines have not been met. Guideline number four states that the patient is not a candidate where surgery or other treatments would clearly be warranted. The records indicate that surgery was recommended. Also, criteria number five has not been met, which states the patient exhibits motivation to change and is willing to forego secondary gains including disability payments to affect this change. There is no documentation that this criteria has been met. This individual has not progressed despite extensive conservative care and six sessions of individual psychotherapy. There is no indication that he is motivated to forego secondary gains. Also, his lack of progress is a negative predictor for success for additional treatment. Therefore, it is neither reasonable nor necessary to provide ten sessions of outpatient chronic pain management program.

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