



**RYCO**  
MedReview

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/27/09

**IRO CASE #:**

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

97799 – Physical Medicine Procedure

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

Licensed in Physical Medicine & Rehabilitation

### **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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

97799 – Physical Medicine Procedure - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient had developed difficulty with primarily low back pain on xx/xx/xx when lifting a piece of material down some stairs with a coworker. He has undergone chiropractic treatment, work hardening, as well as a left L5 selective nerve root block by Dr. His most recent medications were noted to be Flexeril and Darvocet.

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

The records available for review indicate that the current request is for a six-week comprehensive pain management program. In this physician's opinion, a six-week comprehensive pain management program would be excessive for criteria set forth by Official Disability Guidelines. Based upon the records available for review, Official Disability Guidelines would support an attempt at a comprehensive pain management program. However, it is documented that the patient is already functioning at a heavy-duty work level, and as such, one would not anticipate there to be a medical necessity for such an extensive amount of treatment in this program. Official Disability Guidelines indicate that treatment in a comprehensive program is not suggested for longer than two weeks without evidence of compliance and demonstrated efficacy.

Therefore, based on the records available for review, a six week comprehensive pain management program would not appear reasonable and appropriate per Official Disability Guidelines in this particular case.

**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)**