

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 07/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program (97799).

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 private practice of Pain Management full time since 1993

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

Upheld (Agree)

Overtured (Disagree)

Partially Overtured (Agree in part/Disagree in part)

Medical necessity has been demonstrated for ten days of a comprehensive behavioral pain management program

<i>Primary Diagnosis</i>	<i>Service Being Denied</i>	<i>Billin g Modif</i>	<i>Type of Revie</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amou nt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overtu rn</i>
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<i>Code</i>		<i>ier</i>	<i>w</i>						
844.8	97799		Prosp.						Overtu rn

INFORMATION PROVIDED FOR REVIEW:

1. Certificate of Independence of the Reviewer.
2. TDI case assignment.
3. Letters of denial 06/04/10 & 06/23/10, including criteria used in the denial.
4. Reconsideration letter from physician 06/16/10.
5. Physician’s correspondence – consultation 05/25/10 & 05/27/10.
6. FCE 05/25/10.
7. Mental health evaluation 05/25/10.
8. Hand-written correspondence from injured worker, not dated, parts illegible (4 pages).

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This male sustained a work-related fall on xx/xx/xx, which resulted in bilateral knee pain. He underwent surgery for bilateral patella rupture and had postoperative physical therapy, both land and water based. A psychological evaluation and Functional Capacity Evaluation have been performed. The Functional Capacity Evaluation was deemed to be invalid due to submaximal effort.

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

The ODG criteria have been met for the requested ten sessions of a behavioral pain management program. The ODG criteria are listed elsewhere in the record. Each of the criteria have been met. Therefore, medical necessity has been established for the requested ten days of a 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.)