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

DATE OF REVIEW: December 21, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of chronic pain management program to include CPT code #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 Carrier/URA include:

- Official Disability Guidelines, 2008

- EBME, 08/27/05, 10/04/08
- 07/01/08, 09/14/09, 10/06/09, 10/29/09, 11/09/09, 11/18/09, 11/19/09, 11/20/09
- Systems, 01/13/09
- Spine care and Rehabilitation, 09/08/09
- Management Organization, 09/14/09, 10/06/09, 11/11/09, 11/30/09, 12/02/09
- Clinic, 11/03/09
- Texas Workers' Compensation Work Status Report, 11/09/09
- D.O., 11/09/09
- Pre-Authorization Request, 11/11/09, 11/23/09
- Management Services, Inc., 11/17/09

Medical records from the Requestor/Provider include:

- 07/01/08, 09/04/09, 10/29/09, 01/13/09, 11/09/09, 11/18/09, 11/19/09, 11/20/09, 12/01/09
- Spinecare and Rehabilitation, 09/08/09
- Clinic, 11/03/09
- Pre-Authorization Request, 11/23/09
- Network, Inc., 11/27/09

PATIENT CLINICAL HISTORY:

The patient was injured on xx/xx/xx, after falling 12 feet and injuring his ankle and shoulder. He has had extensive conservative and surgical treatment, however, has had persistent pain. He was given a trial of individual psychotherapy and then a ten-day trial of chronic pain management program. The outcomes from this trial do not demonstrate substantial objective functional improvement. His ranges of motions are minimally different. On the Beck Depression Inventory, he is slightly better, however, is worse on the Beck Anxiety Inventory. The documentation suggest that his pain is unchanged by some providers and slightly better by others. Instead of tapering medication, it appears that an opiate pain medication has been added. Additionally, the treating physician indicated that a referral is needed for ongoing ankle symptoms for additional evaluation.

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

The patient does not appear to meet the ODG criteria for a chronic pain management program in that he does not appear to be making significant demonstrated efficacy as documented by subjective and objective means. Furthermore, it appears that the consideration has been given for lower levels of care. Additionally, the treatment outcomes are not well objectified. Returning him to work is discussed, however, given his overall physical functioning on functional capacity examination it is not realistic expectation by the end of programming. It does not appear that there have been efforts to

taper his medications. There is no documentation of what is being performed with respect to vocational rehabilitation. Therefore, the recommendation is to uphold the carrier's non-authorization for 10 sessions of chronic pain management program.

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)