



REVIEWER'S REPORT

DATE OF REVIEW: 05/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten days of a 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 practice of Pain Management full time since 1993

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for an additional ten days of a behavioral pain management program.

INFORMATION PROVIDED FOR REVIEW:

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual was injured on xx/xx/xx and shoulder pain resulted after failure of conservative care. She underwent surgery. Physical therapy was provided, psychotherapy, and antidepressant medications. She recently completed twenty days of a behavioral pain management program. An additional ten days is requested.

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

The ODG criteria states there should be a clear rationale for extension beyond twenty days with establishment of reasonable goals and individual care plan to achieve those goals. This individual has benefited from twenty days of a pain management program. Her depression and anxiety have improved, but her pain is unchanged from 01/14/10 to 03/22/10. It remains at 4/10 to 6/10. The criteria have not been met for an additional ten days since the benefits of the program have been achieved. Coping skills have been

learned, and this individual should be able to utilize the skills learned in everyday life. It is unrealistic to expect that her pain levels would improve since there has been no improvement in two months. It is not reasonable or necessary for an additional ten days.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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.)