

SENT VIA EMAIL OR FAX ON
Feb/26/2010

Applied Assessments LLC

An Independent Review Organization

1124 N Fielder Rd, #179

Arlington, TX 76012

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Chiropractor

AADEP Certified

Whole Person Certified

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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

OD Guidelines

Denial Letters 1/4/10 and 2/3/10

Chronic Pain Management 12/30/09 thru 1/27/10

Work Comp Report 12/18/09

Dr. 11/13/09

Dr. 1/21/10

Dr. 10/14/09 and 10/30/09

FCE 11/6/09

PATIENT CLINICAL HISTORY SUMMARY

The injured employee was involved in an occupational injury on xx/xx/xx when his 18-wheeler struck a side-rail and fell 22 feet to a dry river bottom bursting into flames. He injured his shoulders, right hip and sustained burns to the left hand and face. The injured employee has undergone hospitalization for his burns, physical therapy, injection to the shoulders, MRI of the right shoulder, and psychotherapy for 6 weeks. He was seen by a by a licensed psychologist and underwent a Mental Health Evaluation. The injured employee has been recommended for ten (10) sessions, 80 hours, of chronic pain management, which are now being requested at this time. The injured employee was initially denied due to lack of orthopedic management this is incorrect the injured employee had underwent a pain injection and physical therapy.

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

The injured employee currently does meet the required guidelines for the minimum 10 sessions – 80hours of chronic pain management. Based on a careful review of all medical records and for reasons stated above.

The injured employee meets the guideline criteria as listed below numbers 1 through 11. The numbers correspond with the ODG criteria numbers

1. Chronic pain syndrome with pain beyond 3 months duration,(a) uses prescription drugs, (b) has a dependency on health care providers, (c) deconditioned, (d) withdrawal from work and social contacts, (e) not at pre-injury status, (f) developed psychosocial sequelae see psychological interview, (g) does not have a personality disorder.
2. Loss of function per FCE.
3. Prior methods of chronic pain have been unsuccessful
4. Not a candidate for additional injections or surgery per Orthopedic report
5. Has undergone a multidisciplinary evaluation on 12-02-09
6. Is willing to decrease medication
7. Negative predictors are being addressed.
8. Timing of program
9. Treatment is not suggested longer than 2 weeks.
10. Total treatment not to exceed 20 sessions.
11. No re-enrollment in same or similar program.

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

- ACOEM-AMERICA 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)