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Notice of Independent Review Decision

**DATE OF REVIEW:** April 22, 2010

**IRO CASE #:**

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

Interdisciplinary chronic pain management x 10 days.

**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 include:

- Group, 12/22/09, 01/08/10, 02/15/10, 02/19/10
- Texas Department of Insurance, 04/08/10

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- M.D., 10/28/08, 12/15/09, 01/05/10
- Group, 12/01/09, 12/03/09, 12/07/09, 12/08/09, 12/22/09, 02/10/10, 02/15/10, 02/17/10, 02/22/10, 02/25/10

## **PATIENT CLINICAL HISTORY:**

The request of services is ten sessions of chronic pain management program. The recommendation is upheld.

There is only limited medical information submitted with this case. It appears that the patient was injured on xx/xx/xx, when she fell and injured her lower back.

The patient reportedly had surgery in August of 2009 and has had persistent pain.

The patient participated in occupational therapy in early December of 2009. The patient is on Methadone for pain management.

There is an initial psychological evaluation from January 8, 2010, which documents the diagnosis of a pain disorder. The recommendation is for both chronic pain management program and individual psychotherapy.

There are a couple of notes of individual psychotherapy. The last note indicates that the patient is making significant progress, that she has completed six sessions, and is ready for a tertiary level.

There is an interdisciplinary chronic pain management evaluation which essentially contains the same initial psychological evaluation that was performed prior to her starting individual psychotherapy. There is an occupational therapy evaluation that also appears to be an exact copy of one that was performed in mid December of 2009.

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

I am recommending non authorization for a number of reasons. 1) The patient participated in individual psychotherapy, and the treating provider notes she is making improvement with this. It is not clear why additional sessions were not requested rather than going to a tertiary level of treatment. Furthermore, the occupational therapy and psychological evaluations are not updated. There has been no further objective testing of the psychological functioning or physical functioning since those initial evaluations, which does not substantiate the need for progression to a higher level of care. Also, the treatment goals outlined are non specific. They do not set specific goals to be met or timelines for the patient and have been the same goals that have been outlined since the initiation of individual psychotherapy. Lastly, the patient is working at a job at this point in time. There is no documentation of how this program is going to be accommodated without causing further regression from taking her off of work or, whether it is going to be accommodated within the context of her continuing to work.

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)