



REVIEWER'S REPORT

DATE OF REVIEW: 04/13/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten sessions 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 been established for sessions eleven through twenty of a chronic pain management program.

INFORMATION PROVIDED FOR REVIEW:

1. URA findings and ODG guidelines, 3/3 to 3/23/2010
2. office notes, 12/18/2009 to 4/5/2010
3. office notes, 12/9/2009
4. Functional Testing, FE, 12/1/2009

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a right shoulder injury on xx/xx/xx. After failure of conservative therapy, the claimant underwent a rotator cuff repair and shoulder decompression on 04/29/09. On 08/05/09 a manipulation under anesthesia was performed. Other modalities utilized include physical therapy and psychological

counseling. Ten sessions of a pain management program have been accomplished with modest improvement.

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

There is inconsistency in the review documents. On 11/20/09 there was authorization for ten sessions of a chronic pain management program. Notes from 02/04/10 and a request from 02/09/10 are for a second ten sessions of the pain management program. The peer-reviewed information indicates that twenty sessions were completed. There is no indication in the records reviewed that twenty sessions occurred. The ODG requirements were met for the first ten sessions, and there has been modest improvement. Therefore, the ODG criteria are met for a second ten sessions for a total of twenty.

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.)