SENT VIA EMAIL OR FAX ON
May/15/2010

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 5 X 2

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 3/10/10 and 4/1/10
3/2/10 thru 5/4/10
Center 8/10/09 thru 2/12/10
Diagnostic 8/4/08
MRI 6/7/06

PATIENT CLINICAL HISTORY SUMMARY
The injured employee was involved in an occupational injury on xx/xx/xxxx when she fell over a speed bump and injured her neck and knee. The injured employee eventually underwent a multi-level cervical fusion. The injured employee takes anti-inflammatory medication and an anti-depressant. The injured employee is now. The injured employee has undergone recent psychological evaluation on 3-2-10. It is apparently unknown if the injured employee has ever undergone any psychological treatment or pain management programs or injections or treatments. Records indicate that the injured employee sore mild achy pain which was rated a 3/10VAS and has adequate sleep with interruptions. Medical report dated 2-12-10, does not indicated that the injured employee is on any pain medication and indicated that sore neck pain and mild achy knee pain. Records do not indicate employment history or status since the injury. The injured employee is and it is not likely that she would re-enter the work force. There is no evidence of loss of function for at least the past 3 months. There records indicated an injury in 2001, CT scan of the cervical spine in 2006, an FCE in 2008, and a few office visits at the end of 2009 and at the first of the year. There are records of a CT myelogram of the lumbar spine, which does not appear to be related to the original 2001 injury. Chronic pain management program 5 X 2 is now being requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The injured employee currently does not meet the required guidelines for the 10 sessions of chronic pain management.

1. It does not appear that the patient is on any narcotics or other medication that would require titration or weaning.

2. No current record of an FCE/PPE or other functional study and no evidence of loss of function.

3. No prior indications of treating chronic pain have been successful or unsuccessful.

4. No prior indication that the injured employee has performed lower level pain management or would require any pain injections.

5. It appears that the injured employee has been off work since the injury and there is no current work status in the records.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)