



Notice of Independent Review Decision

CORRECTED REPORT
 Failed to indicate the prevailing party in subject section.

DATE OF REVIEW: 11/09/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Initial chronic pain management program X 80 hours (97799-CP)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Neurology with added qualifications in Pain Management, fellowship-trained in Pain Management

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
296.22	97799	CP	Prosp	80					Overturn

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment.
2. Letters of denial, 09/27/10 and 09/09/10, including criteria used in denial.
3. Request for reconsideration 09/03/10 & 09/20/10.
4. Computerized muscle testing report 08/31/10 and range of motion report 10/05/10.
5. Impairment evaluation, 05/18/10 and 09/01/10.
6. Designated Doctor Evaluations, 04/29/09 and 08/11/10.
7. Behavioral Evaluation Report, 06/23/10.
8. Orthopedic reports, 08/31/10 and 10/05/10.
9. Treating doctor's consultations and reports and follow up notes from 04/06/10 through 08/27/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant sustained a work-related injury on xx/xx/xx and has undergone multiple treatment trials for his chronic pain condition, which has also resulted in some chronic psychological consequences including depression and anxiety.

He has undergone physical therapy, work hardening, multiple medication trials, and various consultations with specialists including orthopedic physicians, etc. Because of a failure to return to work and ongoing chronic pain, as well as psychological issues including depression and anxiety, a multidisciplinary chronic pain management program has been recommended.

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

Though this was initially denied by other reviewers, upon review of records I do feel that this claimant has undergone initial treatment attempts that have not resulted in adequate progress, both from a pain control standpoint and also from various psychological consequences from his chronic pain and failure to return to work, etc. Therefore, I do feel that is reasonable and medically necessary for this claimant to be given the benefits that a chronic multidisciplinary pain program may offer as the next step in treatment.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 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.)