



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

CORRECTED REPORT
Omitted Fax # for Argus Services Corp.

REVIEWER'S REPORT

DATE OF REVIEW: 11/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program X 80 hours

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 private practice of Pain Management full time since 1993

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)

Medical necessity has not been demonstrated for the requested pain management program.

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
307.89	97799		Prosp.		09/27/10 – 10/04/10				Upheld
V62.2			Prosp.		09/27/10 – 10/04/10				Upheld
296.32			Prosp.		09/27/10 – 10/04/10				Upheld
307.90	97799		Prosp.		10/13/10 – 10/21/10				Upheld
309.28			Prosp.		10/13/10 – 10/21/10				Upheld
V62.2			Prosp.		10/13/10 – 10/21/10				Upheld
799.9			Prosp.		10/13/10 – 10/21/10				Upheld

INFORMATION PROVIDED FOR REVIEW:

1908 Spring Hollow Path
Round Rock, TX 78681
Phone: 512.218.1114
Fax: 512.287-4024

1. Certificate of Independence of the Reviewer.
2. TDI case assignment.
3. Letters of denial 10/21/10 & 10/04/10, including criteria used in the denial.
4. Appeal for CPMP (not dated).
5. Chiropractic evaluation 10/10/10.
6. CPMP Treatment Progress Report 09/20/10.
7. Workers' Compensation Medical Report 08/23/10.
8. MRI 07/01/09 and 08/23/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual was injured on xx/xx/xx and has persistent low back pain and depression. She is status post L4/L5 and L5/S1 fusion. Medications have included Vicodin, hydrocodone, ibuprofen, tramadol, skelaxin, ultracet & ambient. She, apparently remains severely depressed; however, I find no documentation of her having been prescribed an antidepressant. No documentation was provided of the patient's having undergone lower levels of care

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

ODG criteria are listed in the medical record. One criterion is that lesser levels of treatment should be exhausted. There is no indication that antidepressants have been prescribed.

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.)