INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/27/11

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Unlisted physical medicine/rehabilitation service or procedure.

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
D.C., Diplomate, Congress of Chiropractic Consultants

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
___ Upheld (Agree)
X__ Overturned (Disagree)
____Partially Overturned (Agree in part/Disagree in part)

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*
726.10	*97799*		*Prosp.*	*10*					*Overturn*

INFORMATION PROVIDED FOR REVIEW:

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The records indicate that on xx/xx/XX, while working the injured worker injured his right shoulder and cervical spine. He has had treatment since his injury.

He has had appropriate clinical workup, appropriate diagnostic testing, to include MRIs, FCEs, PPEs,EMG and psychological testing. He has received medication, injections (right shoulder and cervical spine), right shoulder surgery in 20XX, post-operative rehabilitation and right shoulder surgery in 20XX, with post-operative rehabilitation and a home exercise program. He has exhausted all primary and secondary treatment options.

The treating doctor requested a multi-disciplinary chronic pain management program, that was denied. It was denied again upon reconsideration. The treating doctor wrote a detailed explanation in his request for reconsideration specifically addressing all areas the peer reviewer used to deny the request, thereby, clinically justifying his request.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
The records indicate the ODG guidelines criteria for admission into a multi-disciplinary pain management program to be considered medically necessary have been met. He reports reliance on others to complete activities that he was previously able to complete prior to injury. He has obvious secondary physical deconditioning, evidence by his inability to perform at his required PDL of Very Heavy. He is currently assess as being capable of a medium PDL. The injured worker reports that he often avoids participating in family and social activities due to his pain. He has failed to restore his pre-injury level of function at this point, evidenced by the current PPE, and has not returned to work. He has endorsed severe depression (36) on the BDI-II. He also reports fear/avoidance of activities at home. FABQ-PA score of 19 and FABQ-W score of 33. He has not been diagnosed with a personality disorder or psychological condition

without a physical component. He continues to take Lyrica 75mg 1 po bid. Despite this, he endorses a pain level of 5-7/10, depending on his level of activity. The injured worker has not regained his pre-injury functional stats after physiotherapy, conservative care, individual psychotherapy and surgical intervention.

In addition to meeting the ODG guidelines, documentation presented meets the guidelines of the American Medical Association, The American Academy of Pain Management, American Academy of Physical Medicine and Rehabilitation, The National Guideline Clearinghouse, and American College of Occupational and Environment Medicine for participation in an inter-disciplinary chronic pain management program. Therefore, it is reasonable, usual, customary and medically necessary for this patient to receive the requested 80 hours of a multi-disciplinary chronic pain management program.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE DECISION:

__X___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.
__X__ Medical judgment, 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.
__X___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).

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