



Southwestern Forensic
Associates, Inc.

DATE OF REVIEW: 08/15/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional ten days of 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 not been demonstrated per ODG for an additional ten days of a chronic pain management program.

INFORMATION PROVIDED FOR REVIEW:

1. URA denials, 5/23/11 to 7/14/11
2. office notes and MRI findings 10/3/10 to 2/24/11
3. surgical notes, 10/1/10
4. MD, office notes, 7/27/11
5. Injury One, office notes, 7/6/11 to 7/18/11
6. DC, FCE, 7/5/11

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a back injury on xx/xx/xx. MRI scan demonstrated moderate stenosis at several levels and L5 impingement bilaterally. The EMG study was abnormal at L4, L5, and S1. After failure of conservative treatment, a multilevel decompression laminectomy was performed. Physical therapy and ten sessions of psychotherapy were completed. Work hardening was partially completed. He has undergone ten days of a

behavioral pain management program. There have been modest increases in functionality but minimal to no changes in pain levels.

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

ODG require significant demonstrated efficacy by subjective and objective gains. There has been modest improvement, which does not fulfill these criteria. Extensive similar therapeutic measures including work hardening, physical therapy, and individual psychotherapy have been provided. ODG are not met for an additional ten sessions.

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.)