

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: February 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program: five times a week for 2 weeks (10 Sessions).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

GENERAL AND FORENSIC PSYCHIATRIST
BOARD CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Report, 01/25/XX
- Employer's First Report of Injury or Illness
- Associate Statement – Workers Compensation, 03/15/XX
- Clinic, 03/14/XX, 03/15/XX, 03/16/XX, 03/17/XX, 03/19/XX, 03/22/XX, 03/24/XX, 03/26/XX, 03/29/XX, 03/31/XX, 04/05/XX, 04/07/XX, 04/09/XX, 04/12/XX, 04/14/XX, 04/19/XX, 04/22/XX, 04/29/XX, 04/30/XX, 05/05/XX, 05/25/XX, 05/26/XX, 06/01/XX, 06/03/XX, 06/09/XX, 06/10/XX, 06/15/XX, 06/18/XX, 06/22/XX, 07/12/XX, 07/13/XX, 08/02/XX, 08/04/XX, 08/06/XX, 08/09/XX, 08/11/XX, 08/12/XX, 08/13/XX, 08/16/XX, 08/18/XX, 09/10/XX, 10/12/XX, 10/17/XX, 11/16/XX
- Imaging, 03/19/XX, 03/25/XX
- Clinic, 03/15/XX
- M.D., 03/30/XX, 08/02/XX, 08/04/XX, 10/13/XX
- Clinic, 04/22/XX, 08/12/XX, 08/26/XX, 09/02/XX, 09/09/XX, 09/21/XX, 09/28/XX, 09/30/XX, 10/11/XX, 12/08/XX, 12/09/XX, 12/10/XX, 12/13/XX, 12/14/XX, 12/16/XX, 12/23/XX, 01/05/XX

- Clinic, 12/23/XX, 12/29/XX, 01/05/XX, 01/12/XX,
- M.D., 05/04/XX, 06/08/XX, 07/20/XX,
- Clinic, 05/06/XX,
- Clinic 05/27/XX,
- Clinic, 06/03/XX,
- Clinic, 07/20/XX,
- Clinic, 03/14/XX,

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- Clinic, 10/12/XX, 11/16/XX
- Clinic, 12/16/XX, 01/26/XX

PATIENT CLINICAL HISTORY:

The dispute is for ten sessions of a chronic pain management program. I am going to overturn the carrier's decision.

The patient injured his back while lifting a heavy box on XX/XX.XXXX. The patient had evidence of a herniated disc with radiculopathy that was demonstrated on an EMG study. The patient elected not to have surgery. The patient had been doing physical therapy and injections.

The patient entered into individual counseling and, subsequently, entered into a chronic pain management program. The patient completed seven out of ten sessions of the chronic pain management program. There was an additional ten sessions requested. The data from that programming reveals mixed results with respect to psychological functioning with some measures improving and others mildly worsening. However, there was improvement in his global assessment of functioning, in his cardiovascular endurance, in him making efforts towards reducing his dependence on medications, and improved sleep, as well as improved quality of activities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The ODG Guidelines supports continuation of a chronic pain management program if there are subjective and objective gains. The report accompanying the request reveals multiple subjective improvements. There appears to be some objective gains with his physical functioning. Therefore, continuation of the program for the request of ten sessions seems reasonable.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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 JUDGEMENT, 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)