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Notice of Independent Review Decision

DATE OF REVIEW: October 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management five times a week for two weeks; 80 hours; bilateral wrists and right shoulder. CPT Code: 97799.

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:

- M.D., 10/23/10, 01/24/11
- Care Centers, 04/11/11, 4/28/11, 04/29/11, 05/02/11, 05/03/11, 05/04/11, 05/05/11, 05/06/11, 05/09/11, 05/10/11, 05/11/11
- Care Centers, 06/27/11, 06/28/11, 06/29/11, 07/01/11, 07/05/11, 07/06/11, 07/07/11, 07/08/11
- Pain Center, 08/17/11, 09/08/11, 09/21/11, 10/06/11
- 09/16/11, 10/04/11

Medical records from the URA include:

- Official Disability Guidelines, 2008
- M.D., 10/23/10, 01/24/11
- Care Centers, 04/11/11, 04/28/11, 04/29/11, 05/02/11, 05/03/11, 05/04/11, 05/05/11, 05/06/11, 05/09/11, 05/10/11, 05/11/11
- M.D., 04/28/11, 04/29/11, 05/02/11, 05/03/11, 05/04/11, 05/05/11, 05/06/11, 05/09/11, 05/10/11, 05/11/11
- Care Centers, 06/27/11, 06/28/11, 06/29/11, 07/01/11, 07/05/11, 07/06/11, 07/07/11, 07/08/11
- Pain Center, 08/17/11, 09/08/11, 09/21/11, 10/06/11
- 09/16/11, 10/04/11

Medical records from the Provider include:

- M.D., 01/24/11
- Care Centers, 04/11/11
- Care Centers, 06/27/11, 06/28/11, 06/29/11, 07/01/11, 07/05/11, 07/06/11, 07/07/11, 07/08/11
- Pain Center, 08/17/11, 09/08/11, 09/21/11, 10/06/11

PATIENT CLINICAL HISTORY:

The requested services are for ten sessions of a chronic pain management program. The recommendation is overturned.

The patient is a who fell and experienced bilateral Colles' fractures.

The patient had surgical repair of these fractures. Subsequently, the patient has gone through physical therapy and twenty sessions of work conditioning, which he completed in July of 2011. This moved the patient from a sedentary to medium level of physical demand. The patient's job required a heavy level.

The patient persisted in having pain and plateaued in his physical rehabilitation. The patient was referred for a chronic pain management evaluation and programming.

There was a behavioral health assessment completed. There were ten sessions requested, which was not authorized initially and then again on an appeal.

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

The behavioral health assessment addresses the various criteria in the ODG required for admission to a chronic pain management program. The patient's had deconditioning. The patient has not been able to return to work. The patient has withdrawn from social events. The patient has had sleep disturbance and fear avoidance. The patient does not have a personality disorder. The lower level of treatments has not restored him to full functionality. The psychological measures suggested low levels of anxiety and depression.

However, on the Brief Battery Health Improvement 2, the patient had high defensiveness suggesting reluctance to share information but it did identify significant problems with sleep and multiple stressors, such as chronic pain, financial distress, and unemployment. There is an adequate treatment plan presented. Therefore, the trial of ten sessions of chronic pain management program is 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)**