



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 8/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CHRONIC PAIN MANAGEMENT PROGRAM 5 X WK X 2 WEEKS (10 SESSIONS) 97799 CP

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

M.D. Board Certified in Physical Rehabilitation and Pain Management

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

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	8/08/2011
Utilization Review Determinations	7/18/2011-8/03/2011
behavioral Evaluation and Updated Requests for Services Request for reconsideration	7/08/2011 7/28/2011
Functional capacity Evaluation	6/16/2011



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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xxxx while pushing a cart and the cart suddenly stopped. The claimant pushed the cart with his left foot and reported feeling pain and burning in the ball of the foot. He then had 6 PT visits. Those notes are not presented for review. He then had an MRI of the foot and those findings are not presented for review. He had surgery to the foot on 4/3/2010 and the OP report is not presented for review. He then had 24 post op PT visits and those notes are not presented for review. He had an FCE performed. He has mild anxiety with BAI of 14 and mild depression with BDI of 4. GAF is 60. He has not had any mental health treatment.

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

According to the Official Disability Guidelines: If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity should be clearly identified, as there is conflicting evidence that chronic pain management programs provide return-to-work beyond this period. The patient complains of pain; he did not benefit from other lower levels of care, consisting of physical therapy, and reported chiropractic care. The diagnostic work up or previous treatment provided is not presented for review. He has not had all forms of conservative treatment for his mild symptoms of anxiety and depression. He takes Tramadol, Celebrex, Nexium and Voltaren gel. He is not on medications for his symptoms. He has not had individual psychiatric treatment for his symptoms.

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



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- 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