

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

DATE OF REVIEW: January 10, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program five times a week for two weeks. CPT Codes: 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)

PATIENT CLINICAL HISTORY:

The request of services is a chronic pain management program. The recommendation is overturned.

The patient was injured on xx/xx/xx. The patient strained his back xxxxx
The patient has subsequently undergone conservative treatment to include physical therapy, imaging studies, medications, and work conditioning without substantial improvement in his overall functioning.

The patient underwent an initial psychological evaluation which diagnosed a chronic pain disorder and an adjustment disorder. The patient was recommended to a trial of a chronic pain management program.

The patient had undergone a functional capacity examination which demonstrated an elevated Fear-Avoidance Beliefs Questionnaire score.

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The patient also had a Beck Depression Inventory and Beck Anxiety Inventory, both of which were elevated and indicated significant amounts of anxiety and moderate amounts of depression.

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

The evaluation appears to have covered the ODG criteria for admission to a chronic pain management program and address the negative risk factors, as well as the multiple areas to be addressed in the ODG criteria. The patient has not responded to less intensive interventions. Reportedly, the patient is not a candidate at this point for more intense other physical interventions. Therefore, a trial of the chronic pain management program is reasonable and meets the ODG criteria.

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)