



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 01/29/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Neurology, fellowship-trained in Pain Medicine

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Eighty (80) hours (10 sessions) of chronic pain management.

REVIEW OUTCOME:

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

- Upheld** (Agree)
- Overtured** (Disagree)
- Partially Overtured** (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overtured</i>
			<i>Prosp.</i>				<i>Xx/xx/xx</i>	<i>102694802</i>	<i>Overtured</i>

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 12/14/12 & 01/07/13, including criteria used in the denial.
3. Pre-authorization request 12/28/12 and response denial letter 12/26/12.
4. Treatment progress report update w/mental health testing 12/26/12.
5. Functional capacity evaluation 10/18/12.
6. Radiology reports 08/11/10 and 10/04/10.
7. Operative report 12/20/10 (ESI).
8. Initial orthopedic consultation 10/26/10 and follow up 02/14/11.
9. Neuropsychological evaluation 03/21/12.
10. Otology/neurotology consultation and evaluation 03/17/10. Follow up correspondence 05/24/10 and 07/26/11.
11. Pain management consultation 11/16/10.
12. Nerve conduction velocity/electromyography study 10/07/10.

PATIENT CLINICAL HISTORY (SUMMARY):

This claimant sustained a work-related injury on xx/xx/xx with ongoing chronic pain disorder as well as psychological consequences that have been outlined including notes. Multiple conservative treatment trials have been undertaken including individual psychological therapy, physical therapy, and medication trials. Due to ongoing symptoms and failure to return to her typical work, the request has been made for a chronic pain management program.

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

It is noted that the patient's heart rate and/or blood pressure was elevated with exercise. According to the last reviewer that offered a decline for the proposed treatment, for this reason the claimant should have a medical release based on cardiovascular assessment of function and safety associated with the physical exertion that may be required in a multidisciplinary chronic pain management program, which presumably would include some physical activity and physical therapy as a component. I do agree with the last reviewer that such an evaluation is needed prior to beginning a chronic pain management program. I am in agreement with denial of this requested program.

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 judgment, clinical experience and expertise in accordance with accepted medical Standards
 - Mercy Center Consensus Conference Guidelines
 - Milliman Care Guidelines
 - ODG-Office 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)
-