



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 07/15/13

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, added qualifications in Pain Medicine

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management X 80 hours.

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)

<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 Overturn</i>
840.9	97799		Prosp.	1			Xx/xx/xx		Overturn
840.9	97799		Prosp.	1			Xx/xx/xx		Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letter of denial 06/12/13 & 05/28/13, including criteria used in the denial.
3. Request for consideration 05/22/13, and request for reconsideration 06/06/13.
4. Rationale for authorization 05/24/13 & 06/11/13.
5. Reassessment for PM program continuation 05/21/13.
6. Physical Performance Evaluation 05/13/13.
7. Pain disability questionnaire 03/26/13.
8. FCE 03/22/13.

PATIENT CLINICAL HISTORY (SUMMARY):

This claimant sustained a work-related injury on xx/xx/xx in which he fell and injured his shoulder. Treatments have included analgesics including short-acting narcotics, as well as anti-inflammatory medications, injections, two shoulder surgeries, as well as treatment with physical rehabilitation/work hardening, individual psychotherapy, and the initiation of treatment in a chronic pain management program. His initial treatment in the pain program has yielded some benefit and range of motion of the shoulder, as well as some psychological parameters, although pain levels have not necessarily been subjectively decreased when reported on a Visual Analog Scale. Since the claimant has not yet reached an ability to return to work and he continues to be troubled with shoulder pain, as well as some psychological manifestations from his chronic injury, an additional 80 hours of the chronic pain management program has been requested for further treatment.

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

As the initial treatment trials for the chronic pain management program has already been approved and completed, I feel that it is reasonable to continue with the program as long as some documentation of progress has been made. As the claimant continues to be troubled with pain as well as psychological consequences that apparently continue to hamper his ability to return to work, I feel that the additional requested treatment in the chronic pain management program is reasonable and medically necessary.

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)