



Specialty Independent Review Organization

**Date notice sent to all parties:** 11/19/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

The item in dispute is the prospective medical necessity of chronic pain management program 5x/week x 2weeks, 80 units.

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

The reviewer is a Medical Doctor who is board certified in Psychiatry.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of chronic pain management program 5x/week x 2weeks, 80 units.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female. She has been working. She sustained injury to both her wrists and elbows on XX/XX/XX when she slipped & fell at her worksite while working on a damaged guard rail.

To date she has been treated with pain medications and individual psychotherapy as part of her treatment. XX for her physical and emotional trauma.

This Independent Utilization review has been requested to determine the medical necessity of 10 outpatient sessions of Behavioral Multidisciplinary Chronic Pain management program.

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

The patient underwent an intake psychological evaluation report dated 10/15/2015. It reflects that the patients pain level is @ 4/10, her BDI-II score was 27 (moderate depression), and her BAI score was 3 (sub-clinical anxiety).

MRI study of 06/27/2015, found no fracture/dislocation in elbow or wrist of the patient.

reported, on 8/13/15, a normal NCV/EMG study.

Based on the information above, the reviewer agrees with the original recommendation of return to work with modified duty.

The patient does not meet the ODG criteria; therefore, the requested treatment is not 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 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)
  - DSM 5 - American Psychiatric Association publication.
  - Texas Administration Code for Psycho-social rehabilitation thru CPMP.
    - Practice Guidelines for the treatment of Psychiatric Disorders – an APA publication