

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5x2-80 hours, CPT Code: 97799

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the chronic pain management program 5x2-80 hours, CPT Code: 97799 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for obtaining a review by an IRO – 04/15/09
- Decision letter from – 03/13/09, 03/16/09, 04/08/09
- Mental Health Evaluation by– 08/04/08, 02/18/09

- Chronic pain management program treatment plan/progress report – 02/18/09
- Letter from attorneys to TMF – 04/17/09
- Partial History and Physical by Dr. – 05/15/07
- Office visit note by Dr. – 06/25/07 to 08/07/07
- Report of EMG/NCS – 06/21/07
- Report of chest x-ray – 07/23/07
- Partial Inpatient Hospital Record – 07/25/07
- Initial Evaluation/Examination Physical Therapy – 09/28/07
- Physical therapy progress/treatment notes – 09/14/07 to 01/11/08
- Report of xray of the lumbar spine – 12/03/07
- Report of MRI of the lumbar spine – 01/02/07
- History and Physical by Dr. – 02/26/08
- Report of functional capacity evaluation – 02/27/08
- Office visit note by Dr. – 04/01/08
- Hospital record from Medical Center adm – 04/17/08
- Report of medical record review by Dr. – 05/20/08, 12/18/08
- Worker's Compensation Initial Evaluation Report by Dr.– 06/12/08
- Progress notes from Rehab – 06/25/08 to 02/11/09
- ODG Integrated Treatment/Disability Duration Guidelines Low Back – Lumbar & Thoracic (Acute & Chronic) – 309 pages.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx-xx-xx when she slipped and fell on stairs resulting in injury to her lumbar spine. She has been treated with epidural steroid injections, physical therapy and surgery for a right L5-S1 micro-diskectomy and right L4-5 laminectomy, foraminotomy. The treating chiropractor has recommended that the patient participate in a chronic pain management program.

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

The medical record documentation indicates that this patient has met the ODG guidelines criteria for admission to a chronic pain program. As an injury worker, she is entitled to receive all treatment necessary to assist in recovering from her on the job injury. This chronic pain program will afford her the best opportunity to return to work and recover from her injuries. Therefore, the chronic pain program is medically necessary to treat this patient's condition.

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)