

Notice of Independent Review Decision

DATE OF REVIEW: 08/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management 5X2 97799

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

The TMF physician reviewer is board certified in physical medicine 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 5X2 97799 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 07/16/09
- Notification of reconsideration determination from – 06/01/09, 05/06/09
- Request for review by an IRO from – 07/13/09

- Appeal letter from – 04/03/09
- Request for pre-authorization from – 04/14/09
- Behavioral Medicine Evaluation by– 03/26/09
- Multidisciplinary chronic pain management physical therapy goals by Dr. – 04/24/09
- Physical assessment evaluation and treatment plan by – 02/24/09
- Report of Functional Capacity Evaluation – 04/24/09
- Report of Weekly Schedule for Program for weeks 3 and 4 – no date
- Original Article – Evidence-Based Clinical Practice Guidelines for Interdisciplinary Rehabilitation of Chronic Non-malignant Pain Syndrome Patients.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury while working as and slipped on a 2X4 board while attempting to untangle the straps on a flat bed truck landing on his right shoulder injuring his shoulder, back, neck and head. The patient has been treated with physical therapy, epidural steroid injections and participation in a chronic pain management program. The treating physician has recommended that the patient undergo an addition 10 sessions of chronic pain management.

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

The denial of the requested services raises valid points regarding previous treatment responses. There was a question of whether psychology visits alone would be sufficient and whether narcotic pain reduction was a goal. The provider's response adequately addresses each of these issues and the requested treatment is within the ODG guidelines. Therefore, it is determined that the additional 10 visits to complete the chronic pain program are 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)**