

Notice of Independent Review Decision

DATE OF REVIEW: 02/26/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of daily chronic pain management program

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 pain management 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 20 sessions of daily chronic pain management program is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 02/12/09
- Letter of determination from – 06/04/08, 06/26/08, 07/10/08, 09/23/08, 11/04/08, 12/08/08, 01/05/09
- Request for preauthorization from Dr. – 12/03/08, 01/16/09
- Copy of work Capacity Evaluation – 01/07/09

- Mental Health Evaluation– 12/02/08
- Letter from Dr. – 02/13/09
- Request for reconsideration– 12/22/08
- Daily Progress Notes by Dr. – 09/10/08 to 11/26/08
- Operative Report for right head excision – 06/10/08
- Report of PEER Review– 05/17/08, 12/15/08
- Copy of Prescription and Statement of Medical Necessity by Dr.– 10/03/08 to 10/08/08
- Copy of Prescription for EMS Device by Dr. – 09/26/08
- Notice of Disputed Issue(s) and Refusal to Pay Benefits by Insurance – 07/10/08
- Report of Consultation by Dr. – 09/08/08, 09/22/08
- Report of Designated Doctor Examination by Dr– 08/29/08
- Report of Medical Evaluation – 08/29/08
- Closure report by Services Network, Inc. – 09/29/08
- Office visit notes by Dr. – 06/03/08 to 09/08/08
- Progress Report by Services Network, Inc. – 07/28/08 to 08/27/08
- Operative Report – 07/10/08
- PT progress notes from – 06/27/08 to 07/21/08
- Copy of x-rays of the right radius – 06/12/08
- SOAP for Physical Therapy – 06/18/08
- Retrospective Peer Review Report by Dr. – 07/08/08
- Copy of x-ray of the right elbow – 05/22/08, 05/29/08, 06/10/08
- Neurological History and Physical by Dr. – 06/02/08
- Therapy Prescription by Dr. – 06/23/08
- Orthopedic History and Physical by Dr. – 05/22/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell while walking down a ramp resulting in a right radial head fracture of the right elbow. The patient has been treated with chiropractic care, surgery and post-operative physical therapy.

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

The Guidelines, xxxx Ch. 5&6, stress the need for diagnostic clarity and an individualized time limited treatment plan with clear functional goals as cornerstones of effective treatment. This guideline is not met. The goals are generic boilerplate statements and are not specific for this individual.

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)