

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 1/6/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. 10 sessions of chronic pain management program.

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from New England College of Osteopathic Medicine and completed training in Anesthesiology at University of Medicine and Dentistry of New Jersey. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Anesthesiology and Pain Management since 1992 and currently resides in MA.

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)

1. 10 sessions of chronic pain management program. Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 10/15/2008
2. Pre certification request by, dated 10/14/2008
3. Evaluation note by, dated 10/1/2008
4. Examination findings by MD, dated 9/22/2008
5. Physical performance exam by, dated 10/1/2008
6. Functional capacity evaluation summary dated 10/1/2008
7. Clinical note by, dated 9/8/2008
8. Notification of adverse determination by, dated 10/20/2008
9. Review summary dated unknown,
10. Examination findings by MD, dated 10/20/2008
11. Evaluation note by, dated 10/1/2008
12. Examination findings by MD, dated 9/22/2008
13. Physical performance exam by, dated 10/1/2008
14. Functional capacity evaluation summary dated 10/1/2008
15. Review organization by, dated 12/19/2008
16. Examination findings by MD, dated 2/11/2008
17. Examination findings by MD, dated 3/10/2008 to 11/17/2008 multiple dates
18. Review organization dated 12/18/2008
19. Review organization dated 12/10/2008
20. Notification of reconsideration determination by , dated 10/20/2008 and 11/26/2008
21. Case assignment by, dated 12/19/2008
22. Clinical note dated unknown
23. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Name: Patient_Name

The injured worker is a xx year old male who presented with neck and upper back pain which resulted from an injury. The notes indicate he has been treated with physical therapy, injections, and passive modalities. The request is for 10 sessions of a chronic pain management program.

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

The injured worker had physical therapy and facet injections. He is on Hydrocodone, Mobic, and Ambien. His FCE noted he is at sub sedentary and needs medium/heavy. This report felt work hardening or conditioning was not necessary based on his current testing. This is actually a reason to do work hardening first since he has minimal psych issues to contend with and should focus on his physical functioning mainly. The ODG would allow up to 20 sessions if he shows improvement. His deficit appears to be a physical one so this is what should be addressed rather than a comprehensive pain program at this point. The 10 sessions of a chronic pain management program cannot be considered medically necessary at this time in accordance with ODG. Therefore, the previous denial is upheld.

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)

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