COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: **7/29/09**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 10 sessions of chronic pain management program.

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

Texas licensed Physical Medicine and Rehabilitation/Pain Medicine Physician

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

□ Upheld (Agree)

X 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.

The previously denied request for 10 sessions of chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- **Notice to . of Case Assignment Sheet dated 7/8/09.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) Form dated 7/7/09.**
- **Request Form/Request for a Review by an Independent Review Organization dated 7/6/09.**
- **Certificate of Independence of the Reviewer Form (unspecified date).**
- **Reviewing Physician Recommendation Summary/Letter dated 5/13/09.**
- **Company's Utilization Review Finding's/Letter dated 6/12/09.**
- **Follow-Up /Letter dated 6/19/09, 6/8/09, 6/5/09, 4/24/09, 4/22/09, 4/20/09, 4/14/09, 3/17/09, 3/13/09, 3/5/09, 2/17/09, 1/20/09.**
- **Functional Capacity Evaluation/Letter (unspecified date).**
- **Patient General Information Sheet dated 1/20/09.**
- **Pain Level Evaluation Report dated 1/29/09.**
- **Note dated 3/10/09.**
- **Mini –Mental Status Examination Note dated 3/10/09.**
- **Physical Performance Exam Report dated 6/13/05.**
- **Functional Capacity Evaluation Summary Report dated 3/18/09.**
- **Appeal Request/Letter dated 6/2/09.**
- **Treatment History Report (unspecified date).**
- **Medication History Report (unspecified date).**
- **Integrated Treatment/Disability Duration Guidelines (unspecified date).**
- **Fee Invoice Payment/Letter dated 7/8/09.**
- **Unspecified Document (unspecified date).**
- **Notice of Assignment of Independent Review Organization Sheet dated 7/8/09.**
- **Physical Performance Exam dated 3/18/09.**
- **Functional Capacity Evaluation Summary dated 3/18/09.**
- **Psychological Evaluation dated 3/18/09.**

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Head trauma via being struck by metal

Diagnosis: Facial and ocular trauma, cervicalgia, brachial radiculitis, status post multiple surgeries.

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

This xx-year-old male sustained a multiple trauma occupational injury, dated , xx/xx/xx. At that time, he was performing usual occupational duties as a , when he sustained a significant head injury, with trauma to the facial nerve. He also sustained an associated cervical spine injury. He required multi-specialty treatment including neurology and ophthalmology. He demonstrated a right seventh nerve palsy with exposure keratopathy, cognitive impairment, and chronic cervical pain. He also demonstrated significant disability-associated depression due to the chronic, intractable nature of his condition, which had remained unimproved despite rehabilitation management, including pain management, neurology and ophthalmology specialty care.
In summary, the requested 10 chronic pain management program sessions are medically indicated and within the Official Disability Guidelines criteria. The previous reviewers indicated that because the injury was of greater than 2 years, that this would disqualify the claimant; however, the appeal letter concerning this request accurately stated that the 2-year period is not itself a reason to disqualify the claimant, but usually is associated with a decreased prognosis. However, the request for this type of program in a claimant who has remained in chronic pain with an injury of greater than 2 years, should include post-treatment comprehensive goals. Per criteria #9 “if a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this. The other desirable type of outcomes would include decreasing post-treatment care including medications, injection, and surgery.” According to the appeal letter from the North Texas Rehabilitation Center, the post treatment goals for this claimant would be a reduction of reliance on post-treatment care as one of the outcome goals of participating in a chronic pain management program. The claimant did undergo a psychological evaluation, which indicated that he would be a viable candidate for this type of program and all other conventional treatments for the claimant has been exhausted. Additionally, the prior reviewers of this case have indicated that the reason for non-authorization was that there were no stated vocational or goal. The ODG criteria for multidisciplinary pain management programs do not stipulate that there is a required vocational goal.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), Treatment Index, 7th Edition, (web), Pain – Chronic pain program.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).