

IRO REVIEWER REPORT

DATE OF REVIEW: 09/09/2009

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 and rehabilitation 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 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 08/24/09
- Letter of determination from – 06/29/09, 07/17/09
- Office visit notes by Dr. – 07/30/08 to 01/13/09

- Emergency Department visit to Regional Medical Center – 04/16/09, 07/09/09
- History and Physical by Dr. – 06/01/09
- Patient evaluation by Dr. – 06/05/09 to 07/16/09
- Mental Health Evaluation by – 06/10/09
- Functional capacity evaluation – 06/10/09
- Recheck office assessment by Dr. – 06/15/09 to 07/27/09
- Consultation by Dr.– 08/05/09
- Treatment History for Physical Medicine and Pain Management – 08/26/09
- ODG Treatment guidelines for Pain (Chronic) – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was hit by a drunk driver. This resulted in right shoulder pain radiating down to the right hand, independent right elbow and arm pain. She has been treated with surgery, spinal cord stimulator, Botox injections, medications and pain management. The treating physician is recommending chronic pain management at 5 times per week for 2 weeks.

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

This patient is currently working for a home health company and continues to have upper extremity pain. The treating physician has recommended a functional restoration program as recommended in the ODG and ACOEM Guidelines. This patient meets the documentation guidelines needed as outlined by the ODG for success in a chronic pain program. The outcomes for this patient are favorable, especially considering that she is still in the workforce. Therefore, based on the ODG Guidelines, the treating physician's documentation and considering this patient continues to work at gainful employment, the chronic pain program would be appropriate.

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)