

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 08/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

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 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 program is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 07/22/10
- Letter from attorneys – 07/21/10
- Adverse Determination Notice from – 05/10/10, 06/07/10
- Request for review by an IRO by Dr. and Dr.– 07/16/10
- Appeal letter from Dr. and Dr.– 05/25/10
- Request for pre-authorization by Dr. and Dr.– 04/30/10
- Behavior Medicine Evaluation by Dr.– 01/28/10
- Multidisciplinary Chronic Pain Management Physical Therapy Goals by Dr.– 04/30/10
- Physical Assessment Evaluation and Treatment Plan – 04/27/10
- Summary of Functional Capacity Evaluation – 04/30/10

- Weekly Schedule for Chronic Pain Management Program – no date
- Follow up notes by Dr.– 06/25/10

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was causing injury to his right foot. Imaging studies revealed an avulsion fracture of the tip of the medial malleolus and flexor/extensor tendinosis of the right great toe. The patient has been treated with physical therapy and surgery. The treating physician is recommending a chronic pain management program.

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

Reduction or elimination of narcotic usage is a realistic and helpful goal that can be accomplished through a chronic pain management program. In addition, increasing this individual's activity and mobility level will improve his quality of life and increase the potential for return to at least a sedentary level of employment.

**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)