

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 07/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

70 hours of chronic pain management program between 05/05/10 and 07/04/10

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 70 hours of chronic pain management program between 05/05/10 and 07/04/10 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 – 06/24/10

- Letter of determination– 05/10/10, 05/20/10
- Letter of medical necessity from Dr. – 06/25/10
- Request for reconsideration from Dr. – 05/14/10
- Progress summary from Dr. – 05/03/10
- Pre-authorization request from Dr. – 04/12/10
- Mental health evaluation by Denise – 04/08/10
- Work capacity evaluation report – 04/08/10
- Letter of review– 05/10/10, 05/20/10
- Request for pre-authorization from Pain & Recovery Clinic – 05/17/10
- Copy of ODG Guidelines from Chronic Pain Management Program – no date
- Report of MRI of the right shoulder – 07/23/09
- Report of Medical Evaluation by Dr.– 10/27/09
- Review of medical history and physical exam by Dr. – 10/27/09
- Report of MRI of the cervical and lumbar spine – 11/12/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when a large object fell on his head and back. He apparently developed neck and low back pain, thoracic and shoulder pain. He had a scapular and clavicular fracture. The shoulder MRI showed no rotator cuff tears, but edema/tendinitis of the supra and infraspinatus tendons with AC joint hypertrophy, a chronic finding. He reportedly had compression fractures at T9, T10 and T11. The cervical MRI showed a loss of lordosis and a minimal disc protrusion without herniation or nerve root compression at C6/7. The lumbar MRI showed a 2 mm L4/5 protrusion and 1-2 mm protrusion at L5/S1 as well as neural foraminal narrowing compromised bilateral L5 nerve roots. He has been treated with physical therapy, medications and injections. The patient has participated in a chronic pain management program and the treating physician is requesting an additional 70 hours of chronic pain management program.

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

The ODG has the criteria for pain programs for work related injuries in xxxx. The question is not to start, but to continue a pain program. Both the subjective and objective gains are necessary to continue the program after 2 weeks/10 sessions. The initial FCE provided objective levels before the intervention, but none afterwards. The self reports of pain relief, anxiety, etc are still subjective. The ODG notes that the pain may worsen in a program, but that happens with increased activity. There was no evidence to support this or support the use of

less pain medications. Hence, there was no report that the gains were “being made on a concurrent basis”. Therefore, it is determined that the documentation does not substantiate the medical necessity to continue the pain management program.

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
- AHCPH- 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)