TMF
Health Quality Institute

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Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 10/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Continued chronic pain management program, 10 additional days

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

The TMF physician reviewer is a licensed chiropractor 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 continued chronic pain management program, 10 additional days is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/24/10
- Notice of Review Outcome from – 07/08/10, 07/30/10

- Notification of Suspension of Indemnity Benefit Payment from Services Inc. - 09/22/10, 03/25/10,
- Notification of Maximum Medical Improvement Impairment Income Benefit Payment from Inc. – 09/22/10
- Notice of Disputed Issue(s) and Refusal to Pay Benefits from Services Inc. – 07/30/10
- Notice of Employer Full Salary Payment from Services inc. – 07/30/09
- Notification of First Temporary Income Benefit Payment – 07/30/09
- Supplemental Report of Injury – 07/17/09
- Letter from Inc. – 07/17/09
- Environmental Intervention by Dr and Dr. – 02/15/10 to 05/21/10
- Office progress notes by Dr. – 07/02/09 to 04/20/10
- Assessment/Evaluation for Work Hardening Program by Dr. – 04/27/10
- Physical Therapy Notes from Work and Accident Clinic – 08/26/09 to 08/31/09
- Results of functional capacity evaluation – 04/27/10
- Report of MRI of the Lumbar Spine –02/22/10
- Impairment Rating by Dr. – 09/26/09, 03/25/10
- Individual Psychotherapy Notes by Dr. – 03/05/10 to 04/14/10
- Intermediate Functional Capacity Evaluation – 01/14/10
- Work Conditioning Program Progress Notes – 08/20/09 to 02/26/10
- Psychological Testing Results by Dr.– 12/16/09
- Continued request for Work Conditioning Program by Dr. – 01/25/10
- Initial Functional Capacity Evaluation – 11/09/09
- Patient Progress Notes by Dr. – 11/10/09
- Report of x-rays of the thoracic spine – 09/24/08
- Report of CT of the Lumbar Spine – 08/31/09
- History and Physical by Dr. – 09/22/09
- Initial Behavioral Medicine consultation – 10/30/09
- Comprehensive Re-Examination by Dr.– 09/30/09
- Report of Medical Evaluation by Dr. – 09/09/09
- New Patient Evaluation by Dr. – 06/29/09
- Report of x-rays of the lumbar spine – 12/17/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell into a fourteen foot hole injuring his upper and lower back. Initial imaging revealed a compression fracture at L1 and a disc protrusion at L5-S1. Since his injury he has had appropriate diagnostic evaluations and testing as well as comprehensive treatment. The patient has completed 10 days of a chronic pain management program.

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

The records indicate the patient made several improvements with the initial 10 day trial of a chronic pain program. He was able to discontinue use of hydrocodone and switch to Tramadol. Lumbar range of motion measurements have increased 10-25% and NIOSH listing task improved by almost 10%. He improved overall from PDL rating of "light" to a PDL rating of "light-medium" with a requisite PDL of "Medium-Heavy". He had reduced fear-avoidance beliefs, improved in several coping strategies, reduced disability mindset and improved sleep from 4 hours with 4 awakenings to 5 hours with no awakenings. Functionally he has increased his daily walking routine from 30 minutes to 60 minutes. He is now independently dusting, making the bed, watering plants and all activities for which he required assistance prior to his participation in the program. His tolerance for driving improved from 5-10 minutes to 15-20 minutes and social activities have resumed (non-existent prior to the program).

The records indicate that prior treatment had failed to stabilize his psychosocial distress, failed to increase his engagement in activities of daily living or enhance his physical functioning so that he could safely return to work. Based upon the progress made within the initial 10 day trial of the program, the patient's treating doctor prescribed continued participation in the interdisciplinary chronic pain rehabilitation program and indicated that this treatment is medically necessary. Based on the ODG criteria for continuation of the chronic pain management program, this patient does meet the criteria and required guidelines.

In conclusion, the patient has exhausted all other treatment options and has shown satisfactory improvement from his initial 10 days of the chronic pain management program. Therefore it is determined that the continued additional 10 days in the program is medically necessary.

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)