

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 04/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

80 hours of chronic pain management 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 pain management 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 80 hours of chronic pain management 97799 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 – 04/05/11
- Decision letter from Insurance – 03/16/11, 03/29/11
- Letter to X from Insurance – 04/07/11
- Appeal/Reconsideration by Dr. – 03/22/11
- Chronic Pain Management Program Treatment Plan/Progress Report – 12/17/10 to 02/24/11
- Chiropractic progress notes by Dr. – 12/21/10 to 02/16/11
- Mental health evaluation by Dr. – 12/17/10
- Prescription for MRA of the left knee by Dr.– 03/10/11
- Orthopedic office visit notes by Dr.– 01/13/10 to 03/10/11
- Physical therapy summary of progress – 02/04/10, 02/15/10
- Physical therapy progress notes – 12/28/09 to 03/03/10
- Physical therapy initial evaluation of the left wrist – 10/19/09

- Physical therapy initial evaluation of the knee – 11/28/09
- Report of electrodiagnostic study of the left arm – 08/10/10
- History and Physical by an unknown author – 06/10/10
- Office visit notes by Dr. – 03/12/10
- History and Physical by Dr. – 01/06/10
- Copy of ODG Treatment/Disability Guidelines, Low Back Chapter – 03/21/11
- Chronic Pain Management Program Daily notes – 02/07/11 to 02/18/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when she was sitting down to eat and reached down to pick up a napkin that she had dropped when her chair rolled out from underneath her. This resulted in a fall that injured her left shoulder, left wrist and left knee. The patient has been treated with medications, chiropractic care and physical therapy.

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

The ODG guidelines require that all other modalities be exhausted before considering a chronic pain management program. Based on the information provided for review, a treating orthopedist is recommending injections as well as orthoscopic surgery. Therefore, the criteria in the ODG guidelines have not been met in this case.

**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 KNOWLEDGBASE
- 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)