

SENT VIA EMAIL OR FAX ON
Nov/28/2011

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management

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

Board Certified PMR

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 10/19/11, 10/31/11, 10/03/11

Request for preauthorization for chronic pain management dated 11/14/11, 10/24/11, 10/14/11

Behavioral health evaluation dated 10/04/11

Job description dated 10/14/11

Chronic pain management orientation session dated 10/03/11

Letter dated 10/03/11, 09/30/11

Functional capacity evaluation dated 10/04/11

Handwritten note dated 10/17/11, 09/19/11, 07/25/11, 08/25/11, 05/25/11, 05/10/11, 08/29/11

Physical therapy rehab assessment dated 02/18/11-04/04/11

Initial medical report dated 04/25/11

Orthopedic consultation dated 06/02/11

Follow up note dated 08/15/11, 02/11/11, 01/31/11, 01/14/11

Psychotherapy progress note dated 07/25/11, 08/01/11, 08/15/11, 08/22/11, 09/19/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was crawling in a small work area and subsequently noted right groin and right lateral elbow pain. Treatment to date includes diagnostic testing, physical therapy, individual psychotherapy, elbow and hip injections and medication management. Functional capacity evaluation dated 10/04/11 indicates that the patient's current PDL is sedentary and required PDL is heavy. Behavioral health evaluation update dated 10/04/11 indicates HAM-D is 22 and HAM-A is 2. Diagnosis is pain disorder associated with both psychological factors and a general medical condition, rule out major depressive disorder.

Initial request for 80 hours of chronic pain management was non-certified on 10/19/11 noting that negative predictors of success have not been identified and suggestions for treatment post-program have not been well documented. The denial was upheld on appeal dated 10/31/11 noting that there is no indication as to the specific strategy the program will employ to address each of the negative predictors of success in this case. There is also no specific post-program plan.

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

Based on the clinical information provided, the request for 80 hours of chronic pain management is recommended as medically necessary, and the two previous denials are overturned. The patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient is unable to return to work at her required physical demand level due to functional deficits as evidenced by the functional capacity evaluation dated 10/04/11. The patient also continues with significant signs and symptoms of depression and anxiety despite a course of individual psychotherapy. Given the current clinical data, the requested 80 hours of chronic pain management are indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)