

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 12/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

28 day inpatient 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 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 28 day inpatient Pain Management program 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 – 12/09/10
- Notification of determination– 11/11/10, 11/30/10
- Report of x-rays of the right foot – xx/xx/xx

- Report of x-rays of the right tibia/fibula – 11/30/06
- Report of x-rays of the right knee – xx/xx/xx
- Emergency Medical Service Hospital Report Form – 11/30/06
- Operative Report by Dr. – 11/04/06, 12/01/06, 03/13/07
- Report of x-rays of the right ankle – xx/xx/xx
- Office visit notes by Dr. – 12/11/06 to 09/02/10
- Report of emergency department visit – xx/xx/xx
- Operative Report by Dr. – 12/15/06
- Portion of medical record for admission – xx/xx/xx
- Orthopaedic physical therapy notes – 02/01/07 to 05/30/07
- Independent medical examination– 05/15/07
- Office visit notes by Dr. – 10/15/10 to 08/02/10
- Report of MRI of the right midfoot – 12/14/07
- History and Physical by Dr. – 12/26/07
- Report of fluoroscopy for steroid injections – 01/16/08, 07/30/09, 07/13/10
- Medical evaluation by Dr.– 06/12/08
- Report of MRI of the right ankle – 07/08/08
- Operative report by Dr. – 08/26/08
- Office visit notes by Dr. – 11/06/08 to 04/23/09
- Report of ultrasound of the right extremity – 10/02/08
- Report of CT scan of the right foot – 11/17/08, 07/22/09
- Report of Disability Determination – 01/26/09
- Post Designated Doctor's Required Medical Examination by Dr. – 03/13/09, 09/25/09
- Initial consultation by Dr. – 03/23/09
- Patient Notes from– 02/05/07 to 12/18/09
- Independent Medical Examination by Dr. – 06/15/09, 05/17/10
- Examination by Dr. – 07/22/09
- History and Physical by Dr. – 09/25/09
- Office Visit Notes by Dr. – 09/15/09 to 10/12/10
- Report of EMG ad NCV studies – 10/11/09
- Report of drug screening – 02/08/10 to 11/24/10
- New patient evaluation by Dr. – 03/26/10
- Office visit notes by Dr. – 04/30/10 to 07/16/10
- Office visit notes by Dr.– 09/09/10 to 11/12/10
- Copy of ODG-TWC ODG Treatment, Integrated Treatment/Disability Duration Guidelines **Knee & Leg** (Acute & Chronic) pp. 1-214
- Copy of ODG-TWC ODG Treatment, Integrated Treatment/Disability Duration Guidelines **Ankle & Foot** (Acute & Chronic) pp. 1-122
- Copy of ODG-TWC ODG Treatment, Integrated Treatment/Disability Duration Guidelines **Pain** (Chronic) pp. 1-398

- Copy of ODG-TWC ODG Treatment, Integrated Treatment/Disability Duration Guidelines **Low Back – Lumbar & Thoracic** (Acute & Chronic) pp. 1-348
- Procedure note by Dr. – 10/20/10
- Report of MRI of the lumbar spine – 03/22/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in a crushing injury to multiple sites of the right leg. This included a right open grade 2 tibia fracture, right foot loose frank dislocation, and compartment syndrome of the right calf and foot. The patient underwent surgery to include intramedullary nailing of the tibia as well as fixation of his loose frank foot dislocation. The patient has also been treated with physical therapy, oral analgesics and steroid injections. The latest recommendation is for the patient to attend a 28 day inpatient pain management program.

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

The ODG have not been met for this case. There is ongoing treatment for lumbar radiculopathy and therefore, all other treatment options have not been explored. There has not been a thorough psychological evaluation and there is no documentation that the patient is willing to forego benefits to return to work.

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)