

SENT VIA EMAIL OR FAX ON
Jul/28/2011

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

Amended 7/29/11

Date of Notice of Decision: Jul/28/2011

DATE OF REVIEW:

Jul/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of chronic pain management program

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

Licensed Psychologist

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

1. Cover sheet and working documents
2. Functional capacity evaluation 03/23/11
3. Psychological evaluation 04/04/11
4. Utilization review for 10 sessions of chronic pain management program dated 04/22/11
5. Request for reconsideration dated 05/17/11
6. Physical therapy evaluation and treatment notes 05/20/11
7. Utilization review reconsideration request for 10 sessions of chronic pain management program dated 05/31/11
8. Request for reconsideration IRO dated 06/21/01

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was carrying a load of approximately 250 lbs when he fell in a hole resulting in injury to his back and left shoulder. Treatment to date is noted to include left shoulder surgery in December 2010,

physical therapy and medication management. Functional capacity evaluation dated 03/23/11 indicates that current PDL is light and required PDL is heavy. Psychological evaluation dated 04/04/11 indicates BDI is 5 and BAI is 5. Current medication is listed as Ibuprofen.

Initial request for chronic pain management program was non-certified on 04/22/11 noting that the psychological evaluation is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems. There is no current history and physical by the medical director or a physician associated with the pain program. There is no indication that the patient's treating physician has ruled out all other appropriate care for the chronic pain problem. The denial was upheld on appeal dated 05/31/11 noting that the issues raised by the initial reviewer were not addressed. There was no additional information provided.

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 10 sessions of chronic pain management program is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient is noted to have undergone surgical intervention and physical therapy. The patient presents with Beck scales in the minimal range. The employed psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems. Given the current clinical data, the requested chronic pain management program is not 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 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)