

SENT VIA EMAIL OR FAX ON
Jun/01/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 5 X 2

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. Utilization review determination dated 03/14/11, 04/13/11
3. Comprehensive care plan
4. Functional capacity evaluation dated 02/14/11
5. Psychological diagnostic interview dated 02/14/11
6. Request for chronic pain management dated 02/14/11, 04/06/11
7. Team treatment plan dated 02/14/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a XX year old male whose date of injury is XX/XX/XXXX. On this date the patient sat down in a chair that broke causing him to fall to the floor and resulting in injury to the neck, back and legs. Diagnoses are listed as lumbar radiculopathy, cervical sprain/strain, and thoracic sprain/strain. Functional capacity evaluation dated 02/14/11 indicates that current PDL is sedentary-light and required PDL is heavy. Psychological diagnostic interview dated 02/14/11 indicates that BDI is 20 and BAI is 19. Current medications are Lisinopril, Clonidine HLC, Amlodipine, Metaxalone, Propoxi NAPAP, and Naproxen. Treatment to date is noted to include approximately 24 sessions of physical therapy and medication management. Diagnosis is pain disorder associated with both psychological factors and a general medical condition.

Initial request for chronic pain management program was non-certified on 03/14/11 noting

that the patient presents with subjective complaints of pain without evidence of lumbar pathology to support or explain those complaints, and this is not an indication for CPMP. There is no objective evidence that the patient sustained an injury any more significant than a soft tissue sprain/strain. The patient did not have surgery or even any spinal injections. A tertiary rehab program is not supported for soft tissue strain/sprains since they are inherently self-resolving conditions. The denial was upheld on appeal dated 04/13/11 noting that there is no thorough multidisciplinary evaluation to determine the appropriateness of the program. There is no readily identifiable physical pathology that would explain the patient's ongoing symptoms.

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 chronic pain management program 5 x 2 is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient's subjective complaints appear to outweigh any objective findings. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary, and the two previous denials are upheld.

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)