

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 03/23/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799 Chronic Pain Management Program x10 sessions

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

The TMF physician reviewer is board certified 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 97799 Chronic Pain Management Program x10 sessions 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 – 03/10/11
- Decision letter from– 02/17/11, 03/02/11

- Independent Review Organization Summary from Management, Inc – 03/08/10
- Employers first report of injury or illness – xx/xx/xx
- Notice of Disputed Issue(s) and Refusal To Pay Benefits from Management, Inc. – 04/22/10
- Emergency Department record from Medical Center – 01/28/10
- Office visit notes by Dr. – 02/03/10
- Report of MRI of the lumbar spine – 02/10/10
- Report of x-rays of the lumbar spine – 02/03/10
- Report of EMG of the lower extremities – 03/09/10
- Prescription for PT from Dr. – 02/03/10
- Physical therapy initial evaluation – 02/04/10
- Physical therapy progress notes – 02/16/10 to 03/03/10
- Electro-Diagnostic Interpretation – 03/10/10
- PEER Review by Dr. – 04/21/10
- Initial Consultation by Dr. – 04/26/10
- Explanation of Diagnostic Finding by Dr. – 05/18/10 to 05/24/10
- Report of Computerized Muscle Testing and Range of Motion – 05/12/10 to 08/24/10
- History and Physical by Dr. – 05/07/10
- Chiropractic Progress Notes by Dr. – 05/07/10 to 05/19/10
- Patient re-evaluation by Dr.– 05/28/10 to 01/24/11
- Report of FCE – 05/28/10, 08/20/10, 12/02/10
- Letter of Medical Necessity from Memorial Therapeutic Products – no date
- Pre-Authorization request by Dr.– 06/11/10
- Initial Interview by– 06/16/10
- Office visit notes by Dr. – 06/25/10 to 02/03/11
- Operative Note for epidural steroid injections by Dr. – 07/27/10
- Individual Progress Notes by– 08/02/10 to 09/09/10
- Work Hardening/Conditioning Daily Notes by Dr. – 08/10/10 to 08/30/10
- Designated Doctor's Examination by Dr. – 08/16/10
- Weekly Work Hardening Summary by Dr. – 08/17/10, 08/30/10
- Designated Doctor Dispute by Dr. – 08/30/10
- Orthopedic office visit notes by Dr.– 08/24/10
- Request for a chronic pain management program from – 02/11/11, 02/15/11
- Request for Reconsideration by Dr. – 02/23/11
- Request for Medical Dispute Resolution from – 03/14/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work-related injury on xx/xx/xx when she was stacking bags of grass fertilizer onto shelves when the shelves collapsed and fell on her. This resulted in injury to her lower back. The patient has been treated with medications, chiropractic care, physical therapy, epidural steroid injections and participation in a work hardening program. The request is now for 97799 Chronic Pain Management Program x10 sessions.

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

The ODG criteria have not been met for a pain management program. This injured worker is working and the primary issue is back pain and treatment is ongoing. The ODG criteria number two states that there is an absence of other options available and lower levels of care should be utilized. The injured worker has not been treated with an aggressive regimen of antidepressant medications. Criteria number eight has not been met. There are elevated levels of pain. Therefore, it is determined that the ODG criteria have not been met for participation in a pain management program.

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)