

Notice of Independent Review Decision

**DATE OF REVIEW: 09/13/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management 5x Wk x 2Wks 8hrs/day 97799

**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 anesthesia/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 chronic pain management 5x Wk x 2Wks 8hrs/day 97799 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 – 08/29/11
- Notice of Adverse Determination– 07/05/11
- Notice of Reconsideration Determination– 08/11/11
- Request for appeal for additional chronic pain management sessions– 07/11/11
- Precertification request for additional chronic pain management sessions– 06/29/11

- Evaluation– 11/22/10
- Weekly psychological status with instrument scores – 05/16/11
- Progress notes by Dr. – 10/25/10
- Report of MRI of the thoracic spine and cervical spine – 07/24/08
- Report of MRI of the lumbar spine – 10/20/09
- Final report of MRI of the right knee – 07/13/09
- Report of MRI of the left knee – 09/12/09
- Physical therapy notes from Medical Group – 06/16/09 to 05/26/11
- Initial consultation by Dr. – 09/14/09
- History and physical by Dr.– 08/05/10
- Medication Contract – 06/16/11
- Report of Physical Performance Evaluation – 05/16/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xxxx when he was struck by a rope. The rope caught him behind the knees and caused a whiplash type effect resulting in pain to his neck and thoracic spine. The patient has been treated with surgical intervention to the knee as well as physical therapy and medications. There is a request for 10 sessions of a pain management program.

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

The ODG require an absence of other options likely to result in significant clinical improvement. This patient's primary issue is depression and anxiety which should be treated with oral antidepressant therapy before considering a pain management program. The ODG have not been met.

**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)**