

SENT VIA EMAIL OR FAX ON
Jan/17/2012

Applied Resolutions LLC

An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (214) 329-9005
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain program

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

PM&R and Pain Medicine

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

Cover sheet and working documents

Utilization review determination dated 12/05/11, 12/21/11

PPE dated 10/24/11, 05/17/11

Request for 80 additional hours of chronic pain management program dated 11/29/11

Reconsideration dated 12/14/11

Designated doctor evaluation dated 09/08/11

IME dated 10/07/10

Reassessment for chronic pain management program continuation dated 10/31/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date she was who fell upon her and struggled to get up on his feet. She was trying to hold him up and the examinee was grabbing onto her head. IME dated 10/07/10 indicates that treatment to date includes chiropractic care and medication management. The reviewer opines that the patient does not

demonstrate any positive objective focal abnormalities with regard to this particular injury. There is no indication for any future treatment. Designated doctor evaluation dated 09/08/11 indicates that treatment includes physical therapy, chiropractic care, massage therapy, TENS unit, ultrasound and injections. The patient was determined to have reached MMI as of 05/26/10 with 0% whole person impairment. PPE dated 10/24/11 indicates that required PDL is heavy and current PDL is light. Reassessment dated 10/31/11 indicates that the patient has completed 10 days of chronic pain management program. BAI decreased from 39 to 27 and BDI from 39 to 37. Pain level decreased from 8/10 to 4/10. The patient completed these 10 days without any pain medications. Current PDL remained light.

Initial request for 80 hours of chronic pain program was non-certified on 12/05/11 noting that thus far in the program physical output parameters have shown only trivial improvement. These changes do not justify the continuation of a full time chronic pain management program. There is no documentation of objective, clinically meaningful improvement in physical output parameters, functional status, pain behavior and social functioning. The denial was upheld on appeal dated 12/21/11 noting the issues raised by the initial reviewer were not addressed. There was no additional documentation provided that would impact the prior recommendation for non-authorization.

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 80 hours of chronic pain program is not recommended as medically necessary, and the two previous denials are upheld. The patient has completed 80 hours of chronic pain management program to date with minimal gains. The Official Disability Guidelines support up to 160 hours of chronic pain management program with evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. Beck scales minimally decreased and the patient's physical demand level remained light. Given the lack of significant progress in the program to date, the request for 80 hours of chronic pain 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)