

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 03/13/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program, Total 80 hours

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 family practice 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 program, total 80 hours 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 – 02/28/12
- Decision letter from Mitchell – 01/10/12, 01/20/12
- Request for Preauthorization from Dr.– 01/02/12, 01/16/12
- Request for reconsideration from Dr.– 01/16/12
- Behavioral evaluation report by– 12/01/11
- Work Capacity Evaluation – 12/01/11
- Letter from Dr. to Dr.– 11/07/11

- Letter to TMF from Dr.– 02/29/12
- Office visit notes by Dr.– 03/05/09 to 05/05/09
- Physical Therapy Progress Notes – 03/23/09 to 11/12/09
- Physician office visit notes (illegible name) – 08/25/09 to 02/23/10
- PEER Review of Medical Records by Dr.– 03/25/09
- Addendum to PEER Review of Medical Records by Dr.– 04/02/09
- Comprehensive Medical Analysis– 03/27/09
- Notice of Disputed Issue(s) and Refusal to Pay Benefits – 03/27/09
- Designated Doctor Examination by Dr.– 05/19/09, 09/29/09
- Addendum to Designated Doctor Examination by Dr.– 01/08/10
- Initial Consultation by Dr.– 06/16/10
- Consultation by Dr.– 06/30/10, 09/20/10, 10/04/10, 10/25/10, 12/10/10
- Report of Work Capacity Evaluation – 09/22/10, 12/01/11
- Notice of Disputed Issue(s) and Refusal to Pay Benefits from Broadspire – 05/07/10
- Physician Review Services Peer Review from Broadspire – 04/29/10
- Peer Review/Medical Record Review from glenn-mar – 03/23/11
- Notice of Denied Utilization Review Determination from Mitchell – 05/26/11
- Physician Determination – Initial from Mitchell – 05/25/11
- Follow up visit notes by Dr.– 03/30/11, 05/09/11
- Claim notes – 03/16/11 to 06/27/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was transporting boxes on a pallet that broke. While picking up the boxes to transfer them to a new pallet, he began to experience a painful pull to his lower back. He has been treated with medications, physical therapy, injections and surgery. Documentation states that he has chronic pain, functional deficits, and a secondary depressive reaction. There is a request for 80 hours of a chronic pain management program.

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

This injured worker has received extensive treatment including medication, physical therapy and 6 sessions of psychotherapy. He has been assessed and found to be at maximum medical improvement with no residual disability from his injury. He also suffers from a chronic degenerative process overlying his resolved soft tissue injury. He has received all of the components of a rehabilitation program and this far out, further interventions would be of questionable value. Therefore, it is determined that the chronic pain management program is not medically necessary to treat this patient's condition.

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)