

SENT VIA EMAIL OR FAX ON
Mar/06/2012

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management/Functional Restoration Program X 10 days

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 01/20/12, 02/01/12, 09/15/11, 11/07/11, 09/12/11, 06/07/11

BHI2 report dated 08/09/11

Letter of medical necessity dated 07/28/11

Follow up note dated 07/18/11, 05/17/11, 04/08/11, 03/29/11, 04/25/11, 04/01/11, 04/18/11

Handwritten note dated 07/18/11

Letter of appeal dated 02/13/12, 01/25/12

Patient assessment dated 01/18/12, 09/12/11

Vocational training plan dated 01/18/12

Psychosocial evaluation dated 01/18/12, 09/12/11

PPE dated 01/18/12, 09/12/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient sustained an injury to his back secondary to repetitive lifting. Treatment to date includes x-rays, TENS unit, medication management and physical therapy. PPE dated 01/18/12 indicates that required PDL is medium and current PDL is sedentary. Psychosocial evaluation dated 01/18/12 indicates that the patient underwent 6 sessions of individual psychotherapy with mixed results. BDI is 23 and BAI is 21. Diagnoses are chronic pain syndrome and depressive disorder.

Initial request for chronic pain management program/functional restoration program x 10 days was non-certified on 01/20/12 noting that there is insufficient rationale to establish necessity for a chronic pain management program as the submitted PPE is not validated and he has had little treatment overall with no notable progress in psychotherapy and very little recent active treatment noted. The denial was upheld on appeal dated 02/01/12 noting that the mental health evaluation of 01/18/12 is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms and to help design and predict response to treatment. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem.

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/functional restoration program x 10 days is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no comprehensive assessment of recent active treatment completed to date or the patient's response thereto submitted for review. The submitted physical performance evaluation dated 01/18/12 is not validated and does not appear to be a complete report. The patient's current medication regimen is not documented.

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)