

Notice of Independent Review Decision

DATE OF REVIEW: 04/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 5x Wk x 2Wks 97799 80 hrs Lumbar

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 physical medicine and rehabilitation 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 97799 80 hrs Lumbar 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 – 04/05/13
- Decision letter – 03/07/13, 03/28/13
- Letter via FAX – 04/05/13
- Office visit notes – 03/20/12 to 03/07/13
- PPE Summary & Treatment Recommendations – 08/01/12
- Procedure Note – 11/06/12
- History and Physical – 01/16/13
- Behavioral Health Assessment – 01/16/13
- Functional Capacity Evaluation – 01/16/13
- Letter – 03/01/13
- Follow-up office visit notes – 02/21/13
- Office visit notes – 03/12/12
- Weekly Progress Report – 02/11/13 to 02/15/13, 02/18/13 to 02/27/13, 02/25/13 to 03/01/13, 03/04/13 to 03/08/13, 03/11/13 to 03/15/13, 03/18/13 to 03/22/13
- Copy of ODG-TWCC Treatment Guidelines form Pain (Chronic) 03/21/13
- Letter to TMF – 04/08/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx resulting in injury to his lumbar spine. The patient has undergone treatments in the form of medications, physical therapy, home exercise, work conditioning, epidural steroid injections and two surgeries. The patient is now complaining of back pain radiating into his legs and pain in his left heel. There is now a request for the patient to participate in a chronic pain management program.

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

This is a patient with a work-related back injury from xx/xx/xx and has been off of work since then. He has undergone two lumbar surgeries with fusions to L5-S1 in 2010 and 2012 and his pain has reportedly increased. Between 02/15/13 and 03/22/13 he received 106 hours of an interdisciplinary rehabilitation program and now a chronic pain program has been requested. Due to the length of time since the injury, the chronic use of narcotics, failure to improve with surgery and continued rehabilitation, it is unlikely that he will improve with a Chronic 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)**