

Notice of Independent Review Decision

DATE OF REVIEW: 11/12/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management X 80 hrs, CPT 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 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 X 80 hrs, CPT 97799 is medically necessary to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx resulting in injuries to his left shoulder and hip as well as lacerations to his face. There is a low grade tear to the left supraspinatus and bursitis of the left greater trochanter. The medical record documentation indicates that the patient has undergone extensive physical therapy, injections, excisions and psychotherapy. There is a current request for the patient to undergo a chronic pain management program 5 days a week for 10 days that has been denied by the insurance carrier and is being appealed by the provider.

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

The proposed chronic pain management program is medically necessary to treat this patient's condition. The rationale is based upon the ODG Guidelines and a trial of an 80 hour program to see if surgical intervention, specifically for his left partial rotator cuff tear, should be pursued.

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)