TMF
Health Quality Institute

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Notice of Independent Review Decision

DATE OF REVIEW: 03/18/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 sessions; 5 x/week for 2 weeks, 80 units, low back, 97799

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The reviewer 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 x 10 sessions; 5 x/week for 2 weeks, 80 units, low back, 97799 is medically necessary to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker suffered a low back injury while lifting a heavy plastic tote on xx/xx/xx. An MRI on 10/8/14 revealed mild to moderate multilevel degenerative disc changes and facet hypertrophy at L5-S1, and posterior annular fissure-associated 3 mm

posterior disc protrusion contacting the bilateral S1 nerve root without significant impingement.

He has been treated with conservative care, physical therapy, a TENs unit, medications and a LESI. Diagnostic testing has included x-rays, MRI's, NCS/EMG and a Physical Performance Evaluation (PPE). A psychological evaluation indicated he has been suffering from anxiety, depression, and has developed chronic pain symptoms and has not been able to return to work. He completed psychotherapy sessions but made minimal progress due to poor coping skills, anxiety, and depression and pain complaints. He is experiencing high levels of stress daily including his inability to work and financial issues. His treating doctor requested 10 days of chronic pain management program.

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

The medical record documentation along with the request for the program specifically addresses each circumstance as required by the ODG's for the program to be considered medically necessary. All negative predictors of success have been addressed and will not interfere with him participating in the program. There is a specific documented written plan of action included with the request as required by the ODG's. It is documented that the patient has motivation and agrees to proceed with the recommended treatment. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists, but not limited to, daily pain and stress management groups, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting and returning to a higher level of functioning as possible.

Based upon review of the medical record documentation, this patient has met the ODG guidelines criteria for participation in the requested program. There is sufficient documentation to clinically justify the requested chronic pain management program. The injured worker continues to have documented subjective symptoms and objective clinical findings since his injury and this program will provide him with the best opportunity to improve his quality of live, improve his activities of daily living, learn techniques for pain control, improved fear avoidance behavior, reduce his medication, reduce his dependence upon the health care system and assist him with coping skills to reduce his anxiety and depressive symptoms so he can once again become a more productive member of society with the expectation of him being able to return to full time, gainful employment.

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)**