

Clear Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd. Suite 337-117
Austin, TX 7831

DATE OF REVIEW:

APRIL 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 Sessions of Chronic Pain Management

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

Board Certified, American Board of Physical Medicine and Rehabilitation

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Chronic pain program staffing notes, provider progress notes, treating physician notes, requests for additional pain management days, peer reviews.

- 12/26/06, 2/13/07
- 1/11/07
- Care Center 12/12/.06
- 3/23/06
- 3/21/07, 2/22/07, 2/7/07, 1/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient sustained a lumbar injury at work for which conservative therapy was inadequate. He apparently underwent two back surgeries related to this injury but sustained chronic pain afterward. He has undergone twenty days of a chronic pain management program with reasonable physical and psychological gains.

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

This Patient has had an appropriate time in the chronic pain management program already. He has benefited from it, but at this time it seems certain that he will not return to his former level of activity when he re-enters the work force. The likely permanent gains that would be made with further physical conditioning at this time are not likely to be functionally significant. Further physical training is thus not warranted. His only apparent need at this time seems to be the continuation of counseling services to help him implement functional coping mechanisms. This need, however, does not warrant another ten days of a chronic pain 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)**