

# I-Decisions Inc.

An Independent Review Organization

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## Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 25, 2007**

**REVIEW AMENDED JANUARY 2, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program, 20 days, for lumbar pain as an outpatient.

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

### **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.

Per the *Official Disability Guidelines*, "treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." Given that criteria, a request for 20 sessions is not appropriate.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 11/2/07, 11/28/07

Official Disability Guidelines, Pain

MA, LPC, 10/18/07, 11/7/07

PT, 9/25/07  
D.O. 6/8/07, 6/25/07, 7/3/07, 9/25/07  
Ph.D., Licensed Psychologist, 5/9/07  
D.O., 3/16/07  
Xray Report, 2/2/07  
Electrodiagnostic Study, MD, 6/29/07  
Peer Review Report, 9/6/07  
Diagnostic Inc., 9/11/07, 9/20/07  
MD, 9/19/07  
Functional Abilities Evaluation, PT, 9/25/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while on the job on xx/xx/xx. Since that time, the patient has undergone medial branch blocks with only local anesthetic which were not helpful, not even temporarily, for the patient's low back pain. The patient is also "not a surgical candidate at this time." It is unclear if this was decided by a surgeon. The patient has also been involved in physical therapy and undergone medication management. Despite these treatments, the patient's pain continues. There is a request for the patient to undergo a chronic pain management program for 20 days.

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

Per the Official Disability Guidelines, chronic pain management program "treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." Therefore, even if this patient is a candidate for a chronic pain management program, the patient would not be considered a candidate for 20 sessions.

Another criterion discussed in the *Official Disability Guidelines* states, "previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." It is noted that this patient has only received 1 facet injection from an interventional standpoint.

Given these issues, this patient is currently not considered a candidate per the *Official Disability Guidelines* for involvement in 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)