

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW:

JUNE 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management (10 sessions)

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

MD Board Certified in Anesthesiology

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

Psych and functional capacities evaluation, 03/12/07
Authorization request, 03/20/07 and 05/18/07
Case Management note, 03/22/07
Peer review, Dr., 03/23/07
Request for review by IRO, 05/14/07
Advisory criteria for Pain Management Program, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient is a male with a history of six lumbar surgeries. A psychological evaluation noted complaints of unremitting low back pain, right lower extremity pain and swelling of the right knee. The Patient had treated with multiple medications, physical therapy, epidural steroid injections, transcutaneous electrical nerve stimulation unit, chiropractic and spinal cord stimulator implant without relief. He was noted to be severely deconditioned and functioning at a sedentary level. A request was made for authorization of ten sessions of an interdisciplinary chronic pain management program, eight hours per day, five days per week for two weeks.

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

The Reviewer agrees with the determination of the Insurance Carrier. Ten sessions of an interdisciplinary chronic pain management program eight hours per day, five days per week for two weeks, is not recommended as medically necessary at this time. Based on the medical records provided for review, it would appear that this Patient has had unresolved and incomplete treatment of his severe depression and anxiety. At this time he would not be a good candidate for an interdisciplinary chronic pain management program due to these overlaying issues. The medical records do not establish that the Patient has received a psychological evaluation and treatment to establish the current status of his depression, developed a treatment plan and set realistic goals. After the Patient's depression is treated and the psychologist determines that pain management would be of value, then the pain management treatment program would be reasonable and considered for medical necessity.

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)