

I-Decisions Inc.

An Independent Review Organization

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DATE OF REVIEW: 9/28/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient chronic pain management program times twenty sessions as related to the right shoulder and right side of neck.

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

M.D., Board certified anesthesiologist with Certificate of Added Qualifications in Pain Management granted by the American Board of Anesthesiology and in full time private practice of Pain Management.

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.

There is no medical necessity demonstrated for the twenty-session chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/25/07; 8/14/07

ODG Treatment Guidelines

Records from Dr., Dr., D.C., Dr., Dr., and notes from masters level therapists, including:

Interactive Pain Management Letters, 8/6/07, 7/19/07
Institute, Initial Evaluation, 1/26/06
MRI, 1/23/06
Final Report, Healthcare, xx/xx/xx, Xray of shoulder, Xray of cervical spine
Doctor's Notes, 2/27/06, 3/6/06, 5/10/06
MRI of Cervical Spine, 2/22/06
Orthopedic Consult, 2/16/06
Orthopedic Report, 4/3/06
Letters of Medical Necessity, 2/21/06, 3/16/06, 3/7/06
Institute, Clinical Follow-ups, 2/17/06, 2/6/06, 3/20/06, 4/10/06, 5/1/06
Center, Operative Report and Discharge Summary, 3/31/06
Progress Notes, 3/16/06, 3/7/06, 3/30/06
1/28/00,
EMG, 3/7/06
X-ray, 4/27/06
Dr., Pain Management Initial Evaluation, 7/31/06
Dr., Pain Management, Follow up Evaluations, 9/11/06, 10/23/06, 7/10/07
Dr., Orthopedic Reports, 1/14/06, 12/1/06, 1/26/07, 2/22/07, 4/19/07
Centers, Health Evaluation, 7/5/07
Interactive Pain Management, Individual Psychotherapy Note, no date
Centers, MA LMFT, Psychotherapy Note, 7/11/07
Cervical report, 5/4/06
Clinic Note, 7/25/06
Radiology Report, Cervical Myelogram, 6/17/06
Radiology Report, Post Myelogram of CS, 8/17/06
Side Imagery, Operative Report, 8/17/06
Dr., Notes, 9/1/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a who sustained a work-related shoulder and neck injury. After failure of conservative care, shoulder surgery was performed on 03/31/06, and a C5 through C7 fusion was performed on 12/21/06. Work hardening, physical therapy, psychological counseling, and analgesics were provided postoperatively.

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

The ODG Guidelines for a twenty-session chronic pain management have not been met.

1. There is a lack of a thorough evaluation for this program. The mental health evaluation was cursory performed by a masters level therapist. The usual instruments to determine suitability for a program such as MMPI were not utilized.
2. There is a lack of individualization of the program with no specific goals mentioned. There are only boiler plate statements that do not contain specific goals for this patient.

**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)