I-Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Sessions

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

Board Certified in Physical Medicine and Rehabilitation
Board Certified in 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.

The reviewer finds that medical necessity exists for Chronic Pain Management Program x 10 Sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/25/08, 3/19/08
ODG Guidelines and Treatment Guidelines, Pain Treatment Goals, 2/18/08, 3/10/08
MS, LPC, 10/2/07, 2/15/08, 3/10/08, 6/6/07, 9/25/07

PPE, DC, 2/6/08
DC, 10/5/05

PATIENT CLINICAL HISTORY [SUMMARY]:

This man sustained neck and back pain after a fall from a ladder. He also sustained a concussion with lost of consciousness. He subsequently had PT, chiropractic treatment, facet and lumbar epidural injections for his low back and neck pain. His MRIs showed disc protrusions and bulges with spondylosis in the cervical and lumbar area. The findings were felt to be chronic and predated the injury. One note described a prior back strain treated with surgery, but this was not commented upon elsewhere in the records reviewed. Electrodiagnostic studies were reported as normal. He reportedly was in a chronic pain program, but no records were reportedly found or commented upon in the review. He is not on any opiates. Rather, he is taking Robaxin, Celebrex and Lyrica. In essence, he has chronic neck and low back pain after a fall where the pain generator has not been identified, nor has he had any success with any of the prior treatments.

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

This request is for predominately neck pain. The patient is described as having maladaptive pain behaviors. Recent testing showed both somatic and functional complaints. The patient perceives that his condition and pain are worsening. The medical records show that the patient is motivated, but puts a lot of faith into his doctors curing him. Ms. describes measurable goals on testing, including goals that may translate into improved sleep and function. He is not taking any depressants or opiates and the other medications do not appear excessive. The patient has no prior psychological issues. Ms.'s reports show that the patient has a supportive family. The records also describe a supportive workplace, but the patient has not worked since the company went out of business. The patient had a head injury, yet there are no comments or neuropsychological assessment of any type of post concussion syndrome or cognitive deficit that could be contributing to his pain. He is reported as not being excessively depressed, but having elevated anxiety and pain scores. The records refer to the patient's prior attendance in a pain clinic, however the treatment is not known.

According to the records provided, this patient meets all of the criteria for a chronic pain program as provided in the ODG Guidelines, including:

(1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement;
(2) 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;
(3) The patient has a significant loss of ability to function independently resulting from the chronic pain;
(4) The patient is not a candidate where surgery or other treatments would clearly be warranted;
(5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change;
(6) Negative predictors of success above have been addressed.

Therefore, the reviewer finds that medical necessity exists for Chronic Pain Management Program x 10 Sessions.

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)