Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: **AUGUST 20, 2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program, 5x/week x 2 weeks (10 Sessions)

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

MD, Board Certified by the American Board of Psychiatry and Neurology

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 does not exist for Chronic Pain Management Program, 5x/week x 2 weeks (10 Sessions).

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who was referred to Dr. , M.D., a board certified psychiatrist, on 6/10/2008 for evaluation of chronic pain treatment. A brief history reveals that the claimant was injured in xxxx while working as a for , falling with a resultant injury to her left knee. She has been treated since 1998 by Dr. Treatments include a spinal cord stimulator placed in 1999, extensive physical therapy and participation in a pain support group. Dr. , reviewed the records of the case on 12/31/2007 with the opinion that it was not medically necessary to replace the patient's spinal cord stimulator and that the patient's diagnosis of complex regional pain syndrome was in question. The claimant disagrees, feeling that the stimulator provides her great relief. Following Dr. 's suggestions, Dr. tapered the claimant's medications down. The result has been an increase in pain level. In addition, Dr. 's mental status examination and history revealed the presence of depressed mood, irritability,

anhedonia, decreased interest in activities she used to enjoy, decreased motivation, and changes in sleep and appetite patterns. Beck Depression and anxiety rating scales showed mild anxiety and depression. Dr. recommended that the claimant continue to receive pharmacotherapy and that the dosages be titrated to therapeutic dosages. He also recommended that she participate in a multi-disciplinary chronic pain program to address the physical and psychological aspects of her illness. The request was denied with the following rationale: "There is a lack of significant psychopathology to support the need for a chronic pain management program. BDI and BAI scales (which are subjective) only scored in the mild range. There is no indication in the record that the spinal cord stimulator is malfunctioning." Of some importance is a finding in the old records dated 2/13/2004 from , M.D., an orthopedic surgeon who states: "(she) most likely may have a psychosocial problem relative to her time off of work combined with impressive reaction from this." A note dated 3/15/2006 from M.D., Physical Medicine and Rehabilitation gives her an official diagnosis of "Depression related to chronic pain state."

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

The reviewer finds that medical necessity does not exist for Chronic Pain Management Program, 5x/week x 2 weeks (10 Sessions). The record establishes that the claimant has pain with documentation of psychological problems associated with pain. This is documented in both 2004 and 2006. More recently, Dr. has diagnosed the claimant with mild depression and anxiety. He has recommended pharmacotherapy and a two week pain management program. However, the patient does not meet the ODG criteria for a Chronic Pain Management Program. A multidisciplinary pain program includes physical therapy treatment, for which there is no justification provided in the most recent medical records, including that there is no evidence provided in the records that proves the patient's SCS isn't functioning. The reviewer agrees with the providing doctor that treatment for the claimant's psychological problems should be addressed. However, the recommended treatment by the providing doctor is pharmacotherapy, psychotherapy, or a combination, with the decision to be based upon the patient's preferences.

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)**