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Notice of Independent Review Decision

DATE OF REVIEW: 08-09-2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions chronic pain management program

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

Certified by the American Board of Psychiatry & Neurology; Psychiatry - General

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)

Injury date	Claim #	Review Type	ICD-9/ DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	847.2	97799	Overturned

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Chronic Pain Management Program Preauthorization Request dated 6/30/08
Adverse Determination letter dated 7/8/08
Reconsideration: Chronic Pain Management Program Preauthorization Request dated 7/16/08
Reconsideration determination letter dated 7/24/08
Request for Review by an Independent Review Organization dated 8/1/08
Correspondence throughout appeal process
Functional Abilities Evaluation dated 6/24/08
H&P for Chronic Pain Program dated 6/24/08
Consultation dated 6/4/08
H&P exams dated 5/15/08, 7/12/07, 2/8/07
Medical notes dated 1/30/07, 4/16/07, 9/14/07
Review of Medical History & Physical Exam dated 9/14/07
Follow-up medical reports dated 1/10/08, 4/10/08, 6/9/08
Letter of Clarification dated 6/6/08

PATIENT CLINICAL HISTORY:

The claimant is a male who suffered a work-related injury to his lumbar spine on xx/xx/xx, and subsequently had micro lumbar hemilaminectomy at L4-5 in 9/2006. The patient has complaints of low back pain that radiates into his right leg. Treatment has included diagnostic testing, conservative care surgery, individual psychotherapy, biofeedback training, and a trial of CPMP. The patient is currently reporting severe depression and moderate anxiety. His current pain level is 7/10, and he has difficulty completing his activities of daily living.

The diagnostic impression provided is major depressive disorder moderate to severe and chronic pain. The information submitted for review also indicates that the patient was enrolled in a chronic pain management program in February 2007. There was an incident in which another patient in the program struck him in the back. After this incident he decided to discharge from the program prior to its completion, rather than sign a contract about future behavior, because he felt the contract was unfair, and he felt unprotected and unsupported.

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

In the Reviewer's opinion, 10 sessions of chronic pain management are medically necessary for this patient.

The Reviewer noted the incident at the prior chronic pain management program took place a year and a half ago, and in the Reviewer's opinion the patient had a genuine reason to leave the program at that time. Also, at that time the patient had not exhausted all lower levels of treatment. Since then he has completed other investigations and treatments, including myelogram, CT scan, EMG of lower extremities, evaluation for work hardening, spinal injection treatment, and psychotherapy.

The Reviewer noted that the patient has been adequately evaluated and has a significant loss of ability to function independently resulting from chronic pain. He is currently not a candidate for surgery. He is motivated for change. No negative predictors have been identified. He has exhausted primary and secondary level of pain management without much success. In the Reviewer's opinion, the ODG criteria for admission to a multidisciplinary pain management program have been met 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**

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- 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)**