

# I-Decisions Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW: AUGUST 23, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic Pain Management Program, 5x/wk 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 Orthopedic Surgeon

### **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 the medical necessity does not exist for Chronic Pain Management Program, 5x/wk x 2 weeks (10 Sessions).

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who was injured on xx/xx/xx. He is a male with back pain and bilateral leg pain, numbness, and stiffness, which hurts no matter what. He has had prior physical therapy. He has had an arthroscopy as well as a lumbar fusion and hardware placement in 2000. He has had an epidural steroid injection in November 2007 with mild improvement as well as a similar result in December 2007. He had had individual counseling with L.P.C. on 03/24/08. He apparently has some negative relationship problems, financial occupational problems, and symptoms of anxiety and depression. The records show that he had a chronic pain program two years ago, which he felt was moderately helpful. The goal of the chronic pain program at this point in time is to wean him from all medications, notwithstanding his problems of chronic pain and his sequelae, documented in the medical records of chronic pain problems and chronic

leg problems.

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

ODG Guidelines and general medical knowledge would not support a repeat of the previous chronic pain program for this patient. The reviewer agrees with the previous reviewers that it is unrealistic to expect that when there is a physical basis for this patient's pain complaints that he can be weaned from all narcotic medications and walk away pain free in ten days from a pain management program. The medical necessity of a chronic pain program for a problem that is clearly physical and permanent in the face of previous psychological therapy including previous pain programs is not supported as medically necessary. The reviewer finds the medical necessity does not exist for Chronic Pain Management Program, 5x/wk x 2 weeks (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)