

# US Decisions, Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 19, 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**

MD, Board Certified in Internal Medicine

## **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, 10/6/08, 11/25/08  
ODG-TWC, Pain  
Letter from , 12/8/08  
, MD, 11/11/08, 8/19/08

EMG-NCV, 4/11/08  
, PhD, Clinical Psychologist, 8/20/08  
FCE, 8/13/08  
Dr. , MD, RME, 5/29/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient injured his lower back in xx/xx when he lifted a heavy concrete block. Lumbar MRI showed degenerative changes. He has been treated with medications and therapy with some improvement of his symptoms. He is not a surgical candidate. Mental health evaluation shows depression and a significant loss of function. Functional capacity evaluation shows objective physical deficits. The records show that the patient has insight into his condition and has expressed a desire to improve and a willingness to dedicate himself to this improvement.

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

Outpatient pain rehabilitation programs may be considered medically necessary when the following criteria are met: (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.

This claimant has met the ODG criteria for entry into the program described in the medical records. 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)**