

# Clear Resolutions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 9, 2008**  
**AMENDED DECEMBER 16, 2008**

**IRO CASE #:**

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

Chronic Pain Management Program x 80 hours for 10 Days

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

MD, 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 80 hours for 10 Days.

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

This is a xx year old woman with prior back problems. She reportedly developed back pain from her shoulder blades to her tail bone lifting a 40 pound item (one note) or pushing a cart (another note) while working as a . Her date of injury was xx/xx/xx. Her MRI of 4/17/08 reportedly showed multiple level spondylosis, disc bulging at L4/5 and L5/S1 and facet changes. There was an anterior wedge at L3. Dr. cited that there was no change in this MRI compared to one done on 7/6/06. Examinations cited some subjective left and then right S1 sensory loss, and most of the times, the neurological examination was normal. Dr. felt she was at MMI. She had an evaluation by Dr. on 7/21/08 and was given a 0% impairment rating. She apparently returned to work as a

first on light duty. She apparently continued to complain of back pain and bilateral lower extremity numbness. She apparently attempted to work and developed additional pain and pain behaviors. She was enrolled in a pain program in October 2008. She was described as being somatically focused with chronic pain and adjustment disorder. She had elevated depression and anxiety with reduced motion. These improved with the 10 sessions of pain therapy. Further, she relied on less Darvocet. She however missed several of the 10 sessions due to reportedly minor problems, but was compliant when she came. There is a request for 10 additional treatment sessions.

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

While one of the requirements of a chronic pain program is motivation, and this woman missed several of her prior sessions, she was listed as motivated to improve by the examining physicians and psychologists in the notes provided for this review. She has psychological issues associated with the back strain described in several of the notes. One of the requirements for extension of a pain management program beyond an initial 10 sessions is based on subjective and objective gains. These gains were adequately described in the pain clinic reports. It is based upon the patient's improvements noted in the conference reports, that the reviewer supports the need for the additional treatments. The patient meets the ODG criteria. The reviewer finds that medical necessity exists for Chronic Pain Management Program x 80 hours for 10 Days.

**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)**