

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 20 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 that medical necessity does not exist for Chronic Pain Management Program x 20 Sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/7/08, 11/20/08

ODG Guidelines and Treatment Guidelines

Letter from , MD, 12/4/08, 11/12/08

Preauthorization Request. 10/31/08

Mental Health Evaluation, 10/28/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who, according to the history provided, sustained a 22% burn to the body and is reported to have had a herniated disc and knee surgery. He is currently xx years of age and has not returned to work. The patient seems to have received, based on the records provided, full treatment for his physical medical complaints. He has also undergone some previous psychotherapy, based on the records, although none of the psychotherapy records were provided. A BHE was provided with the records. The current request is for twenty sessions of chronic pain management program.

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

This patient's mental health evaluation reveals a predominant diagnosis and complaints of anxiety and depression. The medical records provided for this review show that this patient's physical problems have already been addressed. Because there is a multidisciplinary component to a chronic pain program, and because this patient's pain complaints are being attributed to psychological issues, and not physical issues, the reviewer was unable to find sufficient information in these records to support the referral to a chronic pain program. In addition, the request for 20 sessions exceeds the initial number of sessions recommended in the ODG. It is for these reasons that the previous adverse determinations have been upheld. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 20 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)**