

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 Additional Sessions of Chronic Pain Management Program

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

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 10 Additional Sessions of Chronic Pain Management Program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 5/6/08, 5/20/08
ODG Guidelines and Treatment Guidelines
Letter to IRO, 6/18/08
12/18/07, 5/1/08, 5/16/08, 2/15/08
Environmental Intervention, 6/12/08
MD, 5/20/08, 2/26/08, 4/1/08, 3/4/08
PT, 4/29/08
MA, LPC, 1/14/08

Operative Report, 3/13/07
MD, 5/1/07, 5/29/07
MRI of Lumbar Spine, 5/4/07
MD, 6/11/07, 9/24/07, 10/8/07, 11/12/07
MRI of Left Knee, 8/2/07
DO, 8/8/07
DO, 9/5/07
Lumbar Discogram, 11/9/07
DC, 12/3/07, 12/11/07, 12/13/07, 12/18/07, 1/2/08
MD, 12/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured in xx/xx. He is diagnosed with right knee sprain/strain and low back pain. The patient's medical history was reviewed and included a knee arthroscopy in March 2007, epidural steroid injections and pain management interventions, including 20 sessions of CPMP. All treatment and progress notes were reviewed. The chiropractic evaluation and assessment were also reviewed.

The records indicated an increase in pain complaints, and an increase in the anxiety scoring (still noted to be severe), after 20 sessions of CPMP had already been completed. Dr. continued to fill the patient's medications at the same rate as prior to the entry into the Chronic Pain Management Program. In April 2008, Mobic was added. The May 1, 2008 FCE noted marginal gains in functionality.

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

As noted in the Official Disability Guidelines, a Chronic Pain Management Program is "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery." Neither of these standards was noted or met in the records presented by the requesting provider. The Official Disability Guidelines also note that a predictor of failure for Chronic Pain Management Programs is "(4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability)." This patient's psychological scores, even after the initial treatments, do not meet the ODG criteria for expectation of a positive outcome. When the reviewer considered the minimal improvement experienced by the patient with the treatment he has already completed, the reviewer concluded that there is no clinical indication for the additional request. Based on all of the above, the reviewer finds that medical necessity does not exist for 10 Additional Sessions of Chronic Pain Management Program.

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)**