

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Sessions (5 times a week x 2 weeks)

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

MD, Board Certified in Orthopedic Surgery
Subspecialty Certification 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 does not exist for Chronic Pain Management Program x 10 sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/31/07, 1/22/08

ODG Guidelines and Treatment Guidelines, Pain

PhD, 12/13/07, 12/6/07

DO, 2/18/08, 1/31/08, 1/17/08, 1/3/08, 12/19/07, 11/29/07, 11/12/07, 9/26/07, 9/6/07, 8/9/07, 6/14/07, 5/31/07, 5/17/07, 5/1/07, 4/27/07, 3/8/07, 3/16/07, 3/2/07, 2/16/07, 1/16/07, 12/6/07, 9/10/07, 1/26/07

Prescriptions, 1/31/08, 1/17/08, 1/3/08, 12/19/07, 11/29/07, 11/12/07, 9/26/07, 9/6/07, 8/9/07, 7/10/07, 6/14/07, 3/16/07, 3/2/07, 2/16/07, 5/1/07
Lumbar Caudal ESI, 5/15/07
MD, 3/6/07, 4/17/07
Daily Progress Note, 3/6/07, 4/17/07
DO, 4/19/05
MD, 11/16/05, 11/14/05
MD, undated
Operative Report, 3/24/06
X-Rays, 1/16/07
Dr. 1/16/07
PT, 12/4/07, 12/13/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when a shelf fell upon him. He underwent a 360 global fusion of his lumbar spine with a subsequent incisional hernia repair. He apparently now suffers from chronic arachnoiditis. The medical records reflect low levels of anxiety and depression related to his pain. He has already had individual sessions of psychotherapy and has manifested a belief that these treatments are not of value for him. He currently lives in a shelter and the records do not reflect a plan for return to employment.

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

Based upon the ODG Treatment Guidelines, in this case, the medical records do not support the use of a Chronic Pain Management Program. This patient has already had physical therapy, conservative care and psychological intervention. The patient has several negative predictors of efficacy of treatment, including negative outlook on future employment and high levels of psychological distress. He does not meet the recommended criteria for Chronic Pain Management Program per the ODG and has significant negative predictors as per the study by Gatchel in 2006. The reviewer finds that CPMP x 10 Sessions is not medically necessary.

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)