

# Clear Resolutions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW: MAY 29, 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 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 10 Sessions.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 4/16/08, 4/17/08, 5/5/08  
ODG Guidelines and Treatment Guidelines  
Letter from Injury 1 to IRO,  
Preauthorization Requests, 4/11/08, 4/28/08  
MS, LPC, CRC, 4/11/08, 4/28/08  
Ph.D., 4/18/08, 5/5/08  
Patient Information Sheet, undated

PT, 4/4/08  
FCE, 4/4/08  
DO, 2/23/08, 2/20/08  
M.Ed., LPC, 11/29/06  
MRI of Lumbar Spine, 12/16/05

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year old man who was injured at work on xx/xx/xx when a telephone pole struck him. He had back pain and leg pain. His MRI showed a small central disc herniation at L5/S1 and at L4/5. He subsequently underwent decompression and a fusion on 6/19/07. The patient apparently had no improvement in his symptoms. His fusion is healing. He continues with deep back pain going to the upper posterior thighs. The records describe marked functional and emotional impairment when initiated into a pain management program. His pain has improved, but has not resolved. He is off tramadol and carisoprodol, but is still on some hydrocodone and ibuprofen. The material supplied by Mr. describes functional improvements and lessened psychological distress with 20 sessions of the pain program and 13 weeks of psychotherapy targeting coping and adjustment. No additional medical or surgical treatment is contemplated. The request is for 10 sessions of a Chronic Pain Management Program beyond the maximal 20 sessions of pain therapy allotted under the ODG. Mr. feels that this man is not at a plateau and that further improvement is likely.

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

The reviewer finds that there is medical necessity for 10 Sessions of Chronic Pain Management Program.

The ODG states that “treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved,” and that “longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. The patient should be at MMI at the conclusion.”

Mr. has described a clear rationale, and has also adequately described the individualized care plans and the risk factors required by the criteria. He has not demonstrated any “proven outcomes.”

However, the ODG states that “the publications are guidelines, not inflexible prescriptions and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions...but they cannot take into account the uniqueness of each patient’s clinical circumstances.”

Weighing the clinical information provided and measuring it against the ODG criteria, the reviewer finds that the extra 10 sessions of pain management are justified. The reviewer finds that 10 extra sessions are medically necessary with the ultimate goal of improved function and gainful employment for this patient.

**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)