

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 10 Sessions (5x/week x 2 weeks)

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

Chiropractor
AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

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 10 Sessions (5x/week x 2 weeks).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/12/08, 7/25/08
ODG Guidelines and Treatment Guidelines, Pain
CPMP & PT Goals, 7/22/08, 7/21/08
, DC, 7/21/08, undated letter, 2/15/08, 9/29/06, 8/26/08

Notes, 2006-2008
, PhD, 7/9/08, 6/14/07, 7/8/07
Operative Report, 12/15/06
Notes, 4/12/08, 3/26/08, 3/11/08, 3/4/08
DDE, 3/6/08
, MD, 12/4/07, 9/20/07, 8/14/07, 2/6/07, 4/17/07
Peer Review, 1/31/07
, 9/5/07
, 2/4/08
FCE, 2/12/08
, PT, PhD, undated letter, 7/24/07
, Jr., MD, 3/21/07, 4/18/07, 2/21/07, 1/24/07, 9/21/06
, 3/6/08
Lumbar Myelogram, 11/29/07
MRI of Lumbar Spine, 11/6/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was injured on xx/xx/xx. He was apparently bending under a forklift to pull a pin and injured his low back. He underwent an MRI on 11-06-2006 and a lumbar myelogram on 11-29-2007, which revealed a 9mm herniation. He underwent several sessions of physical therapy in 2006. He underwent epidural injections and pharmaceutical protocol. The injured employee was seen by a DDE and it was determined that the injured employee was not at MMI. The injured employee was seen by Dr. , MD and recommendations were made for a posterior lumbar decompression, which was eventually performed. A DDE was performed on 3-06-2008 and the patient was assessed at MMI. The injured employee was seen by Dr. , MD, who stated that he does not see evidence for a repeat surgery at this time. The injured employee underwent DOT evaluation and recommendations were that the injured employee is unable to return to work at any capacity. Dr. , MD reported to Dr. that the injured employee is appropriate for an interdisciplinary pain management program for pain focus. The injured employee is now being recommended for 10 sessions of chronic pain management.

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

The injured employee currently does meet the required guidelines for 10 sessions of a chronic pain management program according to the ODG Admission Criteria in view of documentation provided for review.

The injured employee has been properly evaluated by multiple providers and has undergone baseline testing. The previous treatment methods have been unsuccessful, which includes but not limited to physical therapy, medication management, pain injections, and surgery. The injured employee has undergone DOT testing and medical documentation which indicates loss of ability resulting from chronic pain. The injured employee seen by Dr. who indicated that the employee was not indicated for a second surgery. The injured employee is not currently receiving disability payment, and therefore has foregone any secondary gain.

Peer review reports indicated that the services were denied because of: High pain score, fired from job and negative employment outlook, invalid MMPI scores, not currently on opioid medication, better suited for a work hardening program, and motivation of patient to be in such a program. However, the medical report dated 8-26-2008 by Dr. appears

to have adequately addressed all of the areas that were issues in the peer reviews in a very detailed manner. The medical documentation provided in this case concurs with this reported data from Dr. .

In light of the above, the reviewer finds that medical necessity exists for Chronic Pain Management 10 Sessions (5x/week x 2 weeks).

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)