

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 14, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Days

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

M.D., Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and Orthopaedic Surgery

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 Days.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/12/09, 12/16/08
ODG Guidelines and Treatment Guidelines
Preauthorization Request, 12/9/08
, 12/9/08, 12/29/08
Dr. , 12/16/08, 1/12/09

Progress Assessment, 12/5/08
Dr. DO, 9/9/08
, LPC, 5/8/08
Dr. , MD, 5/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old woman who developed back pain on xx/xx/xx. There was no specific injury described in the records, but rather a repetitive jarring. She reportedly had an MRI (1/3/08) that showed disc protrusions at L3/4, L4/5 and L5-S1. An EMG was reported as showing an S1 radiculopathy. She did not improve with epidural injections. She had 20 days of a pain program with some gains including cessation of hydrocodone, but she remains on etodolac, methocarbamol, and sertraline. Reassessment after treatment showed an increase in pain, but a reduction in muscle tension, anxiety and depression. She has improved lumbar motion. Her functional level improved to light medium, but her job, from which she was terminated, required a medium level of physical demand.

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

The claimant has already completed 20 sessions of a chronic pain management program. The ODG is quite clear that the maximum program is 20 days unless there are specifically documented reasons. The ODG states that **“Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. 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.”**

While the records demonstrate that the claimant did make some progress in the program, there was no description from the provider of an exceptional need or clear rationale to warrant an additional 10 sessions. The request exceeds the number of sessions recommended in the guidelines. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 10 Days.

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)