

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 15, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Sessions (97799)

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

MD, Board Certified Orthopedic Surgeon

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 exist for Chronic Pain Management Program x 10 Sessions (97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/14/08, 12/9/08
ODG Guidelines and Treatment Guidelines
Office note, Dr., 09/16/08, 09/18/08, 10/28/08, 11/06/08, 12/12/08
Physical therapy initial evaluation, 09/16/08
Mental health evaluation, 09/18/08

Reconsideration letter, Dr., 10/06/08, 11/20/08
Quantitative functional capacity evaluation, 11/06/08
Fax request, 11/11/08
Fax request, 11/28/08
Peer Review Report, 07/22/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male claimant with reported chronic cervical, thoracic and lumbar spine pain since an injury in xx/xx. The records indicated that the claimant worked as an xxxx and has been working "light duty "for over two years.

The claimant has been diagnosed with chronic cervical radicular pain, chronic non radicular lumbar pain, chronic improved thoracic pain with multilevel degenerative disc disease, persistent deconditioning syndrome and persistent chronic pain syndrome with medical and psychological features. Moderate stressors and mild depression was also noted. Examinations show severely deficient mobility and strength in the lumbar and cervical spines.

A functional restoration program (chronic pain management program, 97799), has been requested for this claimant. The records indicated that the claimant is highly motivated, has been a long term employee and wants to continue working.

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

This claimant clearly has chronic pain and multiple issues, for which he is using chronic narcotic pain medication and is unable to do normal activities. He has had treatment with physical therapy along with other modalities without good improvement. The records of Dr. document the claimant's failure with appropriate conservative care. ODG guidelines for functional restoration programs indicate that patients are acceptable for treatment when they have chronic pain, use chronic narcotic pain medication, have physical deconditioning, have difficulty working and doing other normal recreational activities, and have psychosocial sequela, as well as loss of significant ability to function, previous methods of chronic pain treatment have been unsuccessful, further diagnostic injections are not necessary, and the claimant exhibits motivation to change. Dr. records have clearly answered these questions, and, therefore, it would appear that it is medically reasonable to proceed with 10 sessions of restoration to see if it starts to improve his overall level of activity and function. The reviewer finds that medical necessity exists for Chronic Pain Management Program x 10 Sessions (97799).

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)