

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Mgmt Program - Initial 5 day trial (5 x 1 weeks)

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

MD, PSYCHIATRIST
Certified by the American Board of Psychiatry and Neurology
Licensed by the Texas State Board of Medical Examiners

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/22/10, 10/18/10
Injury Clinic 5/10/10 - 10/12/10
Solutions 10/11/10
M.D. 8/5/10
5/24/10
FCE 5/21/10
4/1/10
Imaging 3/26/10
MD 2/11/10
ODG, Guidelines, 2010

PATIENT CLINICAL HISTORY SUMMARY

The patient is a man who was injured on xx/xx/xx while loading a great number of heavy crates. He twisted and developed back pain and pain down his left leg. He was seen by Dr. on 09/22/2010 for an independent medical evaluation. Dr. summarized his treatment to that point. He had been treated with anti-inflammatory medications and pain medications. He had a prior injury when he was in the military and was diagnosed with spondylolisthesis grade I. When he was hurt in the xxx he had some pain in his back and pain down the left leg with numbness, which went away, only to return after his recent accident. On 03/26/2010 an MRI report noted he has bilateral L5 spondylolysis with a grade I anterior spondylolisthesis at L5/S1. On 02/24/2010 an evaluation by Dr. notes he has a lumbar spinal strain with clinical

disc herniations at L4/5 L5/S1 with left lumbar radiculopathy. Electrodiagnostic testing showed some evidence of L5/S1 radiculopathy bilaterally. The final opinion of the IME was that the patient has a pre-existing spondylolisthesis but a new L5 radiculopathy. The doctor recommended an epidural steroid injection, continuation of Darvocet and monitoring by an orthopedic surgeon 4 times each year. He felt that other treatments, including work hardening or work conditioning are not indicated. He was referred for a chronic pain management program and the following problems were noted: pain, irritability, frustration, muscle tension, anxiety, depression, sleep disturbance. It was noted that he is diagnosed with PTSD, receives treatment from the V.A., and has applied for 100% disability from the V.A.

A request was made for a 5 day trial of chronic pain management. The insurance reviewer who stated that ODG were not met in this case denied this request. Specifically, the reviewer states: "the request is inconsistent with the criterion that the diagnosis is not primarily a personality disorder or psychological condition without a physical component. Thus, this is not an adequate and thorough multidisciplinary evaluation of this patient to determine the appropriateness of a chronic pain management as required by current guidelines."

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

The patient's record indicates that he has a diagnosis of PTSD and is receiving treatment for this at the V.A.. Additionally, the treatment team does not appear to have communicated with the V.A. treatment team to see if they are planning treatment that is redundant. The IME does not recommend any further treatment other than an epidural injection and monitoring of the patient's condition by orthopedics. The specific symptoms to be addressed by the CPM program are stated as: pain, irritability, frustration, muscle tension, anxiety, depression, and sleep disturbance. Every one of these symptoms is commonly seen in patients suffering from PTSD. This reviewer agrees with the prior reviewer that an adequate and thorough multidisciplinary evaluation of this patient to determine the appropriateness of a chronic pain management as required by current guidelines has not been made. Thus the previous denials are appropriate as the request does not conform to ODG. The reviewer finds that medical necessity does not exist for Chronic Pain Mgmt Program - Initial 5 day trial (5 x 1 weeks).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)