

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: April 25, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5xWk x 2Wks (80 hrs) Lumbar 97799

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

MD, Board Certified Physical Medicine and Rehabilitation

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

1. Utilization review determinations dated 02/04/11, 02/28/11
2. Preauthorization request form dated 02/18/11, 02/01/11
3. Reevaluation/request for 10 additional sessions CPMP dated 01/26/11
4. Functional improvement measure dated 01/27/11
5. Cognitive therapy notes dated 01/29/10, 02/12/10
6. Designated doctor evaluation dated 01/20/11
7. Care plan (undated)
8. Psychological diagnostic interview dated 12/23/10
9. MD medical clearance dated 01/19/11
10. ODG, Chronic pain programs

PATIENT CLINICAL HISTORY SUMMARY

The patient is a XX year old male whose date of injury is XX/XX/XXXX. On this date the patient was unloading a truck when an explosion happened; the patient started running and slipped and fell injuring his back, right knee, neck and both elbows. Psychological evaluation dated 12/23/10 indicates that diagnoses include neck sprain/strain, lumbar sprain/strain, herniated disc, muscle spasm and bilateral elbow sprain/strain. BDI is 24 and BAI is 18. Medications include Ambien and Ibuprofen. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. Designated doctor evaluation dated 01/20/11 indicates that the patient reached MMI as of 06/11/09 with 12% whole person impairment. Treatment is noted to include facet block, epidural steroid injection, radiofrequency ablation, cervical spine fusion on 05/12/10. Psychological evaluation dated 01/26/11 indicates that BDI is 16 and BAI is 17. Current medications are Ambien and

Ibuprofen. The note states that in January 2010 the patient completed 12 sessions of a pain management program as well as a course of individual psychotherapy. Most recently the patient has completed 10 sessions of CPMP. Functional improvement measure dated 01/27/11 indicates that current PDL is medium and required PDL is medium. Initial request for 80 hours of chronic pain management program was non-certified on 02/04/11 noting that the number of sessions attended and serial progress reports were not provided. There is no recent patient assessment provided, and no follow up documentation regarding the requisite psychosocial/behavioral component of the program to note his response. The denial was upheld on appeal dated 02/28/11 noting lack of recent patient assessment or serial progress reports to validate the summary of outcomes.

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

Based on the clinical information provided, this request for Chronic Pain Management Program 5xWk x 2Wks (80 hrs) Lumbar 97799 is not medically necessary. The patient has completed 10 sessions of chronic pain management program to date. The submitted records indicate that the patient's Beck scales have improved; however, there is no comprehensive assessment of the patient's functional, objective improvement in the program submitted for review. The functional improvement measure dated 01/27/11 indicates that the patient's PDL is medium, and the summary of outcomes notes that baseline PDL was medium. There is no documentation of significant functional improvement provided to establish efficacy of treatment and support additional sessions of the program. The ODG guidelines have not been satisfied. The reviewer finds there is no medical necessity at this time for Chronic Pain Management Program 5xWk x 2Wks (80 hrs) Lumbar 97799.

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)