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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pain Management five times a week for two weeks

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

Official Disability Guidelines

Progress notes dated 03/02/11 and 04/12/11

Physical performance evaluations dated 04/11/11 and 05/19/11

Reassessment for chronic pain management program continuation dated 06/07/11

Request for 10 final days of chronic pain management program dated 06/15/11

Utilization review request for pain management 5xWk x 2Wks dated 06/20/11

Reconsideration request for final 10 days of chronic pain management program dated 07/06/11

Utilization review appeal request for pain management 5xWk x 2Wks dated 07/13/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting a toilet and felt a burning sensation in his neck and right shoulder. A follow up note dated 03/02/11 reports diagnoses of cervical strain, thoracic strain and left shoulder strain. PPE dated 04/11/11 indicates that treatment to date includes active therapy, 1 cervical injection, individual psychotherapy x 14, biofeedback x 4 and work hardening. Current PDL is light and required PDL is medium. Follow up note dated 04/12/11 indicates that the patient has a surgical evaluation in the near future. PPE dated 05/19/11 indicates that current PDL is light to medium. The patient subsequently completed 20 sessions of chronic pain management program. Reassessment dated 06/07/11 indicates BDI increased from 33 to 36 and BAI decreased from 19 to 15. Pain decreased from 8 to 7/10. Medications are listed as Lyrica, Hydrocodone-Acetaminophen, Flexeril, Cymbalta, Meloxicam. Diagnoses are pain disorder, major depressive disorder and anxiety disorder. CPMP request dated 06/15/11 indicates that current PDL is light-medium.

On 06/20/11 the initial request for 10 sessions of pain management was denied, noting that

ODG reports that total duration of treatment should generally not exceed 20 full day sessions. There is no documentation of improved outcome from the specific facility submitted for review. There is a lack of documentation of any significant improvement in the patient's PDL. The patient's psychometric testing scores and pain rating have not been significantly reduced. The reconsideration report dated 07/06/11 indicates that the patient's pain lowered from 8/10 to 7/10. The patient discontinued usage of Meloxicam, Lyrica, Hydrocodone and Flexeril. The denial was upheld on appeal dated 07/13/11 noting that the requested sessions exceed guideline recommendations. There is no evidence that the remaining physical deficits would require a multidisciplinary management approach. The patient's psychological symptoms remain severe despite 20 sessions of chronic pain management program.

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

Based on the information provided for this review, the reviewer finds this request for pain management five times a week for two weeks is not medically necessary. According to the records, this patient recently completed 20 sessions of chronic pain management program without significant improvement. The Official Disability Guidelines note that total duration of treatment should generally not exceed 20 full day sessions of chronic pain management program. The patient's physical demand level increased from light to light-medium. Pain level decreased from 8/10 to 7/10. The patient continues with severe psychological symptoms despite participation in this multidisciplinary program. There is no clear rationale provided as to why the patient's remaining deficits cannot be addressed with an independent, self-directed home exercise program. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)