US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: August 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 5xwk x 2 wks (97799)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Psychiatrist
Board Certified by the American Board of Psychiatry and Neurology

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines and Treatment Guidelines, Pain Chapter
6/14/11, 7/11/11
6/6/11 to 7/20/11
PPE 4/13/11
MD 7/11/11

PATIENT CLINICAL HISTORY SUMMARY
The patient is a man whose date of injury is xx/xx/xx. He was injured while lifting equipment when a pulley gave way, jerking his entire body. A peer review dated 04/04/11 indicates his diagnosis is lumbosacral strain and is expected to be fairly well resolved. Further medical treatment is listed as home exercise and OTC anti-inflammatory medication. Patient was listed as able to return to work with no restrictions. Physical performance rated him as light and required PDL is heavy. He has also undergone psychotherapy and physical therapy. The Request for Services dated 06/06/11 says that he made minimal progress in psychotherapy. He was able to decrease average pain levels from 8 to 6-7. He did improve some in group therapy sessions, but retains an overwhelming fear of being reinjured. A request was made for 10 sessions of CPMP.

This request was denied. The following rationales were given: “The records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this procedure. The records indicate that the patient has undergone MRI and x-rays only.” The response from the treatment team to this item was to note: “All lower levels of care have been exhausted. There are no additional treatment procedures pending.”

The second reviewer denied the service with this rationale: “The patient underwent 6

sessions of individual psychotherapy and did not make any significant progress. Psychological indicators are minimal. There is no documentation of the patient's compliance and progress with a home exercise program." The response "Patient demonstrates a combination of symptoms of depression and anxiety, along with fears of functioning and problems with sleeping habits." "Patient responded well to individual therapy sessions, decreasing their amount of symptoms of depression and anxiety; and is expected to build upon and solidify this success."

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

The first concern is that the patient may not have exhausted all lower levels of care. The treating team has said simply this is not true, but has not provided any documentation to back up this claim. Additionally, the patient's response to psychotherapy is uncertain, as there are no psychotherapy notes or assessments included. In one note, the team states that the response was not good and lists a slight decrease in pain as the only result. In the reply, the team states there was a decrease in depression and anxiety. But again, there is no documentation to back up this statement. There is not enough evidence in the records reviewed that this patient is an appropriate patient for CPMP according to the Official Disability Guidelines. The reviewer finds that medical necessity does not exist at this time for Chronic Pain Management 5xwk x 2 wks (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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)