US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (512) 782-4560
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Additional Chronic Pain Management Program 5xWk x 2Wks 80 hours 97799

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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
11/17/10. 11/24/10
Dr., 11/10/10-12/9/10

PATIENT CLINICAL HISTORY SUMMARY
This is a female patient with a date of injury of xx/xx/xx. Notes indicate prior treatment with PT, acupuncture, ESI and chiropractic treatment for her pain. One reviewer cited prior 160 hours in a pain program followed by 80 hours in this program and a request for an additional 80 hours as being not warranted. Another reviewer notes the patient received 160 hours in a pain program starting 12/09. Additional pain programs were requested and started and then denied. Dr. notes she had been in a pain program with 50% improvement in cervical motion and reduced pain from 8 to 5. He did not comment on lumbar pain in either of his notes. Mr. described the pain as 4/10 on 11/10/10. She had lumbar pain and migraine headaches. He wanted her to have additional treatment sessions as the BDI and BAI improved. His 12/08/10 report listed cervical, thoracic and lumbar pain. He cited improvement in the BAI and BDI. There was no FCE provided in the records.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
Dr. describes a cervical problem. Mr. describes a lumbar problem and migraines in one note and lumbar, thoracic and cervical pain in another. Neither Dr. or Mr. have commented on the previously attended 12/09 pain program that is referenced in the peer reviews. There is

inadequate and conflicting information. There is a comment about her entering DARS, but no comment of her functional level. This would document any objective improvement. It is unclear if she had 80 or 160 or 240 hours of a pain program to date. There is no report of injury or work sought. There is no FCE to demonstrate objective improvement. ODG for continuation in a pain management program is not satisfied. The reviewer finds that there is no medical necessity for Additional Chronic Pain Management Program 5xWk x 2Wks 80 hours 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)