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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
97799 Cont. Chronic Pain Management Program x 10 Sessions

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured on xx/xx/xx at work. She developed back pain. From the summary provided by and Mr., she received PT, chiropractic care and a spinal injection. She was not found to be a candidate for surgery.

She completed 20 sessions of a pain program. It was noted her pain level decreased from 7 to 6.5. She had some improvement with anxiety, depression, irritability, frustration, sleep, avoidance. She remains on 3 hydrocodone a day and can not seem to get below this level. Her PDL improved from sedentary to light, but her job requires her to be at a medium PDL. On 10/4/10, wrote that the indication for the extra treatment was "This increase level of care is needed to reduce this patient's pain experience, develop self regulation skills, and facilitate a timely return to the work force..." The request also said that it is "medically necessary for any lasting management of her pain symptoms and related psychosocial problems..." Mr. replied in a 10/26/10 appeal of the denial stating in response to the ODG

requirement that there be a “clear rationale for the specified extension and reasonable goals.” He wrote of her goals that “Treatment will aim to enhance her functioning and teach her proper skills to promote a successful return to work.” It would also “increase her functional tolerances for safe/successful return to work while reducing perceived disability.”

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

The patient has chronic pain and had been in a chronic pain program. Normally, this type of treatment is limited to treatment within 24 months of injury. This claimant is over 3 years post injury and received special consideration for the treatment program. The ODG allows for additional treatment but “requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).” The information provided by both not identified beyond this signature and Mr. are very generalized. No specifics were given in the records that were provided. There was no explanation in the records why the chronic pain program had not been successful in the 20 sessions already completed. Based on the material provided and the ODG, the reviewer finds there is no medical necessity for 97799 Cont. Chronic Pain Management Program x 10 Sessions.

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)