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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Management Program 5xwk x2wks

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

MD, Board Certified in Physical Medicine and Rehabilitation and Pain Management

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

ODG-TWC Treatment Guidelines

Utilization review determination dated 05/03/11, 05/17/11

CPMP preauthorization request dated 04/28/11

Reconsideration request dated 05/10/11

Functional capacity evaluation dated 04/05/11

History and physical chronic pain management program dated 04/14/11

Chronic pain management interdisciplinary plan and goals of treatment dated 04/14/11

Initial behavioral medicine consultation dated 07/23/10

Follow up note dated 03/31/11, 04/25/11, 05/23/11

Work hardening daily note dated 04/06/11, 04/07/11, 04/12/11

Group therapy note dated 04/06/11, 04/07/11, 04/12/11

Assessment dated 04/15/11

Patient activity flow sheets

Reassessment/discharge for work hardening program dated 04/08/11

Interdisciplinary program team conference dated 04/11/11, 04/18/11

Environmental intervention note dated 04/27/11

Report of maximum medical improvement/impairment dated 05/31/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date and the patient underwent surgical repair of his lung on 09/11/09. Treatment to date is noted to include physical therapy, TENS unit, individual psychotherapy x 12 and an injection. Initial behavioral medicine consultation dated 07/23/10 indicates that BDI is 25 and BAI is 19. Diagnoses are pain disorder and PTSD. The patient subsequently completed 20 sessions of a work hardening program. Functional capacity evaluation dated 04/05/11 indicates that current PDL is light and required PDL is medium. Mental status evaluation dated 04/08/11 indicates that BDI is 7 and BAI is 10. Report of maximum medical improvement/impairment dated 05/31/11 indicates that the patient has reached MMI with 11% whole person impairment. The insurance company denied the request for CPMP stating that the DD reported that no further

treatment is necessary other than possible follow up treatment with a psychiatrist. It is not clear how this patient would benefit from a chronic pain program given the lower levels of psychological treatment he has had and recent participation in a work hardening program for 20 days with no attempts to return to work thereafter. The denial was upheld on appeal dated 05/17/11 noting that there is no clear rationale provided to support a multidisciplinary program at the same facility with the same providers when the patient has completed 12 individual psychotherapy visits, 40 group psych sessions and 20 work hardening days under their direction.

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

This patient was determined to have reached maximum medical improvement by a designated doctor who noted that no further treatment is necessary for this patient other than possible follow up treatment with a psychiatrist. The patient recently completed a work hardening program, yet his physical demand level remains at light and there is no indication that the patient has attempted to return to work in any capacity. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program to include work hardening and note that chronic pain management programs should not be considered a stepping stone after less intensive programs. Given the clinical records provided for this review, the reviewer finds that the requested 97799 Chronic Pain Management Program 5xwk x2wks is not indicated as medically necessary.

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)