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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management (10 sessions)

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

M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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, Pain Chapter

Utilization review determination dated 11/07/11, 11/22/11, 10/11/11, 08/22/11, 08/16/11, 03/22/11, 01/18/11, 05/06/10, 03/02/10, 11/18/09

Letter dated 11/29/11

Request for reconsideration for preauthorization of additional chronic pain management dated 11/14/11

Collaborative report for medical necessity of chronic pain management program dated 11/11/11, 11/01/11

Behavioral health evaluation dated 07/12/11

Tertiary team committee meeting dated 09/26/11

Pain therapy program contract undated

Massage therapy notes dated 11/02/10, 11/17/10

Relaxation group notes dated 11/02/10, 11/17/10

Functional capacity evaluation dated 08/09/11

Handwritten notes dated 10/13/11, 09/13/11, 06/15/11, 05/17/11, 05/16/11

Orthopedic follow up report dated 09/28/11, 08/30/11

Follow up note dated 09/12/11, 06/20/11, 07/07/11, 07/23/09, 12/02/10, 04/08/10, 07/26/10, 07/12/10, 06/04/09, 11/05/09

Radiographic report dated 09/26/11, 09/22/08

Lumbar CT myelogram scan dated 05/28/09, 07/30/08

EMG/NCV dated 07/16/09

Cervical CT dated 09/22/08

Cervical MRI dated 07/16/10

Lumbar MRI dated 07/27/11

Cervical myelogram dated 10/23/08

Post myelogram CT dated 10/23/08
Procedure report dated 04/29/11
Operative report dated 03/11/09
Initial medical report dated 06/24/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx while moving equipment from a truck when he slipped and fell. He had C4-T1 fusion on 03/11/09, cervical epidural steroid injections, occipital nerve blocks, diagnostic testing, physical therapy, spinal cord stimulator with subsequent removal and chronic pain management program. Behavioral health evaluation dated 07/12/11 states that the patient reports episodes of depression and anxiety. Medications include Norco, Valium, Zanaflex, Ambien, Elavil and Naproxen.

HAM-D is 15 (moderate) and HAM-A is 15 (mild). Diagnosis is pain disorder associated with both psychological factors and a general medical condition, depressive disorder. Functional capacity evaluation dated 08/09/11 states that the patient performed at a frequent sedentary and an occasional light PDL. Required PDL is very heavy. Tertiary team committee meeting dated 09/26/11 indicates that the patient has decreased Norco by 50%. The patient was successfully weaned from muscle relaxers in the program. A collaborative report dated 11/01/11 states that HAM-D is 15 and HAM-A is 15.

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

This man has previously completed a chronic pain management program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. The patient's date of injury is over 3 years old. The Official Disability Guidelines do not recommend chronic pain management programs for patients whose date of injury is greater than 24 months old as there is conflicting evidence that these programs provide return to work beyond this period. For these reasons, the reviewer finds there is not a medical necessity for 80 hours of chronic pain management (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)