

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPMP, 5 x 2 weeks (10 sessions, 80 hours)

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

M.D., Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

It is the opinion of the reviewer that the requested CPMP, 5 x 2 weeks (10 sessions, 80 hours) is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was working and xxxxx. An evaluation states that the patient continued to work light duty until she was terminated on. She had PT x 9 and medication management. She was placed at MMI by a designated doctor as of 03/26/10 with 5% whole person impairment. Extent of injury is noted to be a cervical spine strain superimposed on underlying disc disease. Functional capacity evaluation dated 02/09/12 indicates that current PDL is sedentary and required PDL is medium. Initial diagnostic interview dated 05/05/12 indicates that BDI is 21 and BAI is 30. Diagnoses are adjustment disorder with mixed anxiety and depressed mood, and depressive disorder, nos, related to injury medical condition. The patient subsequently underwent 4 pro-bono sessions of individual psychotherapy as request for individual psychotherapy was denied by carrier. Diagnostic interview dated 06/05/12 indicates that current medications are Myoflam gel, Antispasm gel and Flexeril. Beck scales are unchanged. FABQ-W remains 42 and FABQ-PA remains 24.

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

This patient has been diagnosed with depressive disorder; however, the patient is not currently taking any antidepressant medication. The patient underwent 4 sessions of individual psychotherapy with no change in Beck or fear avoidance scales. The patient has been determined to have reached maximum medical improvement by a designated doctor as of 03/26/10 with 5% whole person impairment. The designated doctor notes that extent of her injury is noted to be a cervical spine strain superimposed on underlying disc disease.

As noted by a previous reviewer, the patient's functional capacity evaluation indicates that the patient has already met the work required PDL noted on the DOT and there is no information from the employer to the contrary. The Official Disability Guidelines do not generally support chronic pain management programs for patients who have been continuously disabled for over 24 months as there is conflicting evidence that these programs provide return to work beyond this period. Given the current clinical data, it is the opinion of the reviewer that the requested CPMP, 5 x 2 weeks (10 sessions, 80 hours) 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)