# Clear Resolutions Inc.

**An Independent Review Organization**
**6800 W. Gate Blvd., #132-323**
**Austin, TX 78745**
**Phone: (512) 879-6370**
**Fax: (512) 519-7316**
**Email: resolutions.manager@cri-iro.com**


## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/15/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Chronic Pain Management Program (5 days a week for 3-4 weeks) total of 10 days

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
M.D., Board Certified Anesthesiology/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
Initial visit and follow-up notes M.D. 08/22/11-03/26/12
Lower extremity EMG/NCV 08/31/11
Independent Medical Evaluation dated 12/27/11 Dr.
Functional capacity evaluation dated 12/29/11
Physician's orders 12/29/11
Procedure report transforaminal epidural steroid injection L5-S1 dated 01/04/12
Notice of independent review decision dated 02/09/12
Chronic pain management program patient treatment goals and objectives dated 04/17/12
Initial diagnostic screening with mental health testing dated 04/17/12
BHI-2 testing dated 04/20/12
Utilization review determination dated 04/26/12
Response to denial letter dated 05/14/12
Initial diagnostic screening with mental health testing update dated 05/14/12
Utilization review determination dated 05/22/12

**PATIENT CLINICAL HISTORY SUMMARY**
The patient is a female whose date of injury is xx/xx/x. On this date the patient was lifting a box and twisting from center. The patient noticed low back pain. IME dated 12/27/11 indicates that treatment to date includes physical therapy, medication management, epidural steroid injection and diagnostic testing. Diagnosis is lumbosacral strain superimposed upon disc pathology at the L5-S1 level. Ongoing orthopedic treatment is opined to be necessary; however, active physical therapy, work conditioning and work hardening are not necessary. Initial diagnostic screening dated 04/17/12 indicates that current medications are Carisoprodol, Hydrocodone, Gabapentin and Skelaxin. BDI is 21 and BAI is 12. Diagnosis is

adjustment disorder with depressed mood, due to a medical condition.

Initial request for chronic pain management program was non-certified on 04/26/12 noting that the mental health evaluation is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. There is no current history and physical by the medical director or a physician associated with the pain program. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem. It is unclear how the patient requires a chronic pain program given the diagnosis of adjustment disorder, without indication of a pain disorder or chronic pain syndrome or behavioral evaluation. The denial was upheld on appeal dated 05/22/12 noting that there is no current, detailed physical examination submitted for review and no updated functional capacity evaluation was provided.
The functional capacity evaluation submitted for review is from December 2011 and notes that the patient has almost achieved her required PDL of light-medium with a PDL of light at the time. It is unclear why the patient cannot achieve her required PDL with a lower level of care such as physical therapy, home exercise program or work conditioning program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**
The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for a CPMP. There is no current functional capacity evaluation submitted for review to establish baseline levels of functioning as well as current versus required physical demand level. The submitted functional capacity evaluation is dated 12/29/11. The ODG criteria for a CPMP has not been satisfied. No reason has been provided for why there should be a divergence from the ODG in this particular patient's case. The reviewer finds there is not medical necessity for Chronic Pain Management Program (5 days a week for 3-4 weeks) total of 10 days.

**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)**