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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Chronic Pain Management Program x 10 days

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

M.D., Board Certified Anesthesiology 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

Official Disability Guidelines

Utilization review determination dated 01/04/12, 02/07/12

Patient treatment goals and objectives dated 01/20/12, 12/20/11

Initial diagnostic screening dated 01/20/12, 12/20/11, 09/01/11

CT lumbar spine dated 05/02/11

Follow up note dated 05/17/11, 08/09/11

Designated doctor evaluation dated 09/26/11, 02/08/11

Response to denial letter dated 10/21/11

Comprehensive evaluation dated 01/24/12

Functional capacity evaluation dated 12/01/11, 07/20/11

Notice of independent review decision dated 11/14/11

Reevaluation dated 02/14/11

Operative report dated 08/13/10

History and physical dated 08/13/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. She was transferring loaded boxes on a flat dolly when one of the boxes began to slip. She reached and pushed against it and experienced severe low back pain. She has had lumbar surgery (L4-5 bilateral decompression, L4-5 discectomy, L4-5 transforaminal lumbar interbody fusion, L4-5 posterolateral segmental instrumentation, L4-5 posterolateral arthrodesis) on 08/13/10, physical therapy, epidural steroid injections, diagnostic testing and medication management. Designated doctor evaluation on 02/08/11 indicates that impairment rating is 5%. Initial diagnostic screening dated 09/01/11 indicates that BDI is 14 and BAI is 26. Diagnosis is pain disorder associated with work related injury, medical condition and psychological factors; adjustment disorder with mixed anxiety and depressed mood, acute. A course of individual

psychotherapy was recommended. Designated doctor evaluation dated 09/26/11 recommends Rehab training. Functional capacity evaluation dated 12/01/11 indicates that required PDL is medium and current PDL is sedentary. Psychological evaluation dated 12/20/11 indicates that medications include Gabapentin, Soma, Cymbalta, Lipitor, and Lisinopril. BDI is 14 and BAI is 26. Diagnostic screening dated 01/20/12 reports that medications are unchanged.

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

The Official Disability Guidelines do not support chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. This patient's date of injury is 4 ½ years old. The patient was recommended to undergo a course of individual psychotherapy; however, the submitted records fail to establish that this treatment was completed. Given the current clinical data, the reviewer finds the requested Outpatient Chronic Pain Management Program x 10 days 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)