

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/26/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** chronic pain management program / 80 units /or 5 days per week x 2 weeks

**A 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)

**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 request for chronic pain management program / 80 units /or 5 days per week x 2 weeks is not recommended as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 01/02/13, 01/31/13

Request for services dated 12/26/12

Functional capacity evaluation dated 11/20/12

Request for reconsideration dated 01/23/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as pulling on a book cover. Functional capacity evaluation dated 11/20/12 indicates that the patient complains of intolerable pain in her neck and right shoulder. Current PDL is light and required PDL is medium. Request for services dated 12/26/12 indicates that the patient has completed a course of individual psychotherapy. Pain level decreased from 8/10 to 6/10. BDI decreased from 30 to 17 and BAI increased from 9 to 13.

Initial request for chronic pain management x 80 hours was non-certified on 01/02/13 noting that the patient has improved with individual psychotherapy. Per IME dated 12/14/12, treatment plan would be to consider several injections of Marcaine and steroid and perhaps physical therapy given in conjunction with that. There is no indication that this treatment plan has been implemented, and therefore the submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level

program. The denial was upheld on appeal dated 01/31/13 noting that case notes indicate that injection therapy may be pending. There was no documented evidence or information to the contrary. The claimant has completed a prior physical therapy and psychotherapy with equivocal outcomes. There was also no documentation of prior treatment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no treatment records provided. The patient reportedly underwent an IME in December 2012 which recommended a treatment plan consisting of injection therapy and possibly physical therapy. This report is not submitted for review, and there is no indication that the recommended treatment has been completed. The patient's current medication regimen is not documented. As such, it is the opinion of the reviewer that the request for chronic pain management program / 80 units /or 5 days per week x 2 weeks is not recommended 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)