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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 10 initial sessions of multidisciplinary chronic pain management program

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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)

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 10 initial sessions of multidisciplinary chronic pain management program is not recommended 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. The mechanism of injury is not described. PPE dated 05/12/14 indicates that required PDL is heavy and current PDL is sedentary. Request for services dated 05/15/14 indicates that the patient has completed a course of individual psychotherapy. BDI decreased from 22 to 18 and BAI from 25 to 17. Treatment to date is noted to include lumbar fusion in 2000 with subsequent hardware removal, SI joint injection, lumbar epidural steroid injections and medication management. Current medication is hydrocodone.

Initial request for 10 sessions of chronic pain management program was non-certified on 05/21/14 noting that when considering the claimant's date of injury and her scores on the Beck Depression Inventory coupled with her clinical assessment of anxiety and depression, with no evidence that these conditions are undergoing any other treatment other than the psychotherapy previously noted which resulted in some improvement, but consistent scoring on the depression scale evidencing the diagnosis, it is unclear that all negative predictors of success have been addressed and treated prior to consideration for this program. Request for reconsideration dated 05/28/14 indicates that the patient completed postoperative rehabilitation sessions following removal of hardware in 2002. The denial was upheld on appeal dated 06/04/14 noting that she does not have a job to return to. She has exceeded the recommendation of the guideline of being outside of two years of injury. Her PDL at this time is sedentary. She needs to get to a medium PDL. She continues to have high incidence of taking medication and her BDI is now 18 and BAI is under 17.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries. The Official Disability Guidelines do not generally 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. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. The submitted records indicate that the patient does not have a job to return to at this time. As such, it is the opinion of the reviewer that the request for 10 initial sessions of multidisciplinary chronic pain management program 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)