

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/15/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management, additional 80 hours

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

M.D., Board Certified Anesthesiology; Board Certified 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. The reviewer finds medical necessity does not exist for Chronic pain management, additional 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical evaluation 06/13/12

Undated treatment plan

Behavioral health assessment 06/13/12

Pre-authorization letter 07/25/12

Weekly progress report 07/27/12

Appeal letter 07/31/12

Peer review 06/12/12

Prior reviews 07/30/12 and 08/06/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained an injury on xx/xx/xx when she fell. She attended a chronic pain management program from 07/23/12-07/27/12. The weekly progress report dated 07/27/12 covered three days of treatment. In regards to the claimant's physical function, the claimant did make improvements from her initial values up to day 8 where she exhibited increased capabilities with floor to waist lifting, waist to shoulder lifting, and shoulder to overhead lifting. Grip strength right versus left did not significantly improve. In regards to range of motion, the claimant made minimal improvements in the lumbar spine. The claimant did make significant improvements in wrist range of motion. The claimant's Hamilton depression scale was reduced by two points and the claimant's numeric pain scale was reduced by one point. The request for 80 additional hours of chronic pain management was denied by utilization review on 07/30/12 as there was a lack of symptoms to support ongoing chronic pain management. The request was again denied by utilization review on 08/06/12 as there was no in depth physical examination performed to evaluate the claimant's condition after the initial 80 hours of chronic pain management. The clinical notes also

indicated that the claimant was previously prescribed a neurostimulator in 05/12, and with physical therapy, the claimant was allowed to return to work with 0% impairment and a reported pain scale of 0/10 on the VAS.

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

Based on the limited weekly progress report provided for review, there is insufficient objective evidence of functional improvement to warrant continued chronic pain management. The claimant made some improvements with physical function.

However, no significant functional improvement was made. The claimant's psychosocial functions were not adequately reevaluated and no in depth physical examination was provided for review demonstrating persistent functional limitations that would reasonably require additional chronic pain management. It is unclear what the claimant's medications have been to date and it does appear that the claimant had significant pain relief and functional ability restored with treatment prior to a chronic pain management program. The clinical documentation provided for review does not meet guideline recommendations. The reviewer finds medical necessity does not exist for Chronic pain management, additional 80 hours.

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)