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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours Chronic Pain Management Program for the right knee, left ankle, cervical, thoracic and lumbar spine

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

Board Certified Chiropractic Examiner

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 06/25/13, 7/12/13, 05/30/13
Office note dated 05/10/13, 06/04/12, 05/02/12, 04/03/12
Procedure note dated 06/28/07
Request for reconsideration dated 07/09/13
Initial interview dated 04/11/13
Handwritten note dated 04/11/13
Letter dated 08/02/13
Behavioral evaluation and updated request for services dated 06/07/13
Functional capacity evaluation dated 05/17/13
Muscle test dated 05/10/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the claimant was climbing a scaffold ladder when the ladder gave way. The patient fell and landed on his feet. Initial interview dated 04/11/13 indicates that treatment to date includes x-rays, MRIs, physical therapy, chiropractic, pain injections, TENS unit, surgery (right knee arthroscopy on 06/28/07) and aquatic therapy. BDI is 0 and BAI is 0. Diagnosis is chronic pain disorder associated with both psychological factors and a general medical condition. Functional capacity evaluation dated 05/17/13 indicates that current PDL is less than sedentary and required PDL is medium. Behavioral evaluation dated 06/07/13 indicates that medications include

Oxycontin, Flexeril, Nabumetone, Adderall, and Wellbutrin. Individuals with the patient's MMPI profile are within normal limits. The patient was recommended for 10 sessions of a chronic pain management program.

Initial request for 80 hours of chronic pain management program was non-certified on 06/25/13 noting that guidelines state, "patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below." Additionally, guidelines state, "There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (>24 months)". This claimant is 15 years post injury. The denial was upheld on 07/12/13 noting that the primary purpose described for the request for 10 sessions of a chronic pain management program is to address long-term narcotic usage. There is no record of a screening evaluation. There is no record of a medication titration plan. There is no specific patient response regarding willingness to change medication regime. There is no specific patient response regarding the understanding that successful treatment may change compensation and/or other secondary gains

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

The patient sustained injuries in xxxx. 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. The primary purpose described for the request for 10 sessions of a chronic pain management program is to address long-term narcotic usage. There is no clear rationale provided as to why this cannot be accomplished with a less intensive setting or why an interdisciplinary chronic pain management program is necessary to address the patient's medication usage. As such, it is the opinion of the reviewer that the request is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES