

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Dec/09/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Chronic pain management program-80 Hrs/Units-outpatient

**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 Chronic pain management program-80 Hrs/Units-outpatient is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 11/12/13, 10/17/13  
PPE dated 09/16/13  
History and physical dated 09/24/13, 07/23/13, 02/09/12  
Plan and goals of treatment dated 09/18/13  
Psychological testing and assessment report dated 10/03/13  
Initial behavioral medicine consultation dated 12/14/11  
Reassessment for work hardening continuation dated 09/18/13  
Preauthorization request dated 10/10/13  
Reconsideration dated 11/04/13  
Follow up note dated 11/19/13, 09/03/13, 08/09/12, 07/12/12, 06/07/12, 05/03/12, 04/19/12, 03/22/12  
Biofeedback training note dated 08/01/12, 07/26/12, 06/28/12, 06/19/12, 06/07/12, 04/25/12  
Individual psychotherapy note dated 07/26/12, 06/28/12, 06/19/12, 06/07/12, 04/25/12, 04/17/12, 03/16/12, 06/06/12, 02/29/12, 02/21/12, 02/09/12, 01/26/12  
MRI lumbar spine dated 10/28/11  
MRI right shoulder dated 10/26/11  
MRI left shoulder dated 10/26/11  
MRI right knee dated 10/27/11  
MRI left knee dated 10/27/11  
MRI thoracic spine dated 10/27/11  
Psychological assessment report dated 02/24/12  
Work hardening program discharge summary dated 09/27/13  
Work hardening team conference dated 09/24/13, 09/17/13

Work hardening daily note dated 09/23/13, 09/20/13, 09/18/13, 09/17/13, 09/13/13, 09/12/13, 09/11/13, 09/10/13, 09/06/13, 09/05/13, 09/03/13  
Health and behavioral reassessment dated 07/25/13  
Exercise flow sheet dated 09/03/13-09/23/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. Treatment to date includes physical therapy, diagnostic testing, individual psychotherapy, biofeedback, medication management, left knee surgery x 2 and most recently 10 sessions of work hardening program. PPE dated 09/18/13 indicates that required PDL is very heavy and current PDL is light-medium. Reassessment for work hardening program continuation dated 09/18/13 indicates that BDI is 45 and BAI is 47. Medication is lisinopril. Diagnoses are listed as major depressive disorder, single episode, severe without psychotic features; and pain disorder associated with both psychological factors and a general medical condition, chronic. Psychological testing dated 10/03/13 indicates that BDI is 42 and BAI is 35. MMPI profile is invalid and uninterpretable due to inconsistent responding.

Initial request for chronic pain management program 80 hours was non-certified on 10/17/13 noting that the patient has previously completed a work hardening program with some progress. The work hardening program should have been completed. The patient reports severe depression, but has not been placed on any psychotropic medications. His MMPI was uninterpretable answers; the patient does not seem very motivated. Reconsideration dated 11/04/13 indicates that he increased his PDL in the work hardening program by 10 lbs. Although he exhibits some mood disturbance that lead to his referral to Dr., he prescribed Elavil 100 mg for his mood. The denial was upheld on appeal dated 11/12/13 noting that there is no documentation of his previous findings indicating any improvement from previous multidisciplinary treatment. As such, the requested chronic pain management program would not be indicated as there is no documentation that the patient was motivated to change and is noted to have somatic complaints and significant beliefs of functional disabilities, which were not noted to have decreased with the previous work hardening program. There is no indication that the patient has received any medications for treatment of his severe depression or anxiety or is taking any medications for treatment of his reported severe pain.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient presents with Beck scales in the questionable range and MMPI profile is noted to be invalid. The patient has completed a previous work hardening program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. The patient does not appear motivated to change. The patient is not currently taking any narcotic medications. As such, it is the opinion of the reviewer that the request for Chronic pain management program-80 Hrs/Units-outpatient 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)