True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
May/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program 5 X 2

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Designated doctor examination dated 09/17/11
Clinical note dated 02/20/13
Requests for services dated 04/03/13 & 04/16/13
Previous utilization reviews dated 04/10/13 & 04/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who reported an injury regarding his cervical region. The designated doctor exam dated 09/17/11 details the patient stating the initial injury occurred. The note details the patient having previously undergone a MRI which revealed mild bony hypertrophic changes at the C2-3, C3-4, and C4-5 levels. The clinical note dated 03/22/13 details the patient continuing with complaints of cervical region pain. The patient also reported numbness and tingling in both hands. Radiating pain was noted to the left elbow. The note does detail the patient having undergone a functional capacity evaluation which revealed the patient able to tolerate a medium physical demand level. The patient's occupation does require a heavy physical demand level. The patient rated his pain at that time as 4/10. Range of motion restrictions were noted throughout the cervical region. The letter of request dated 04/03/13 details the patient undergoing a battery of psychological examinations. The patient was noted to have scored a 31 on his BDI-2 indicating severe depression. The patient scored a 28 on his BAI indicating moderate anxiety. The patient's FABQ-W was noted to be 41 and the FABQ-PA was noted to be 18.

The previous utilization review dated 04/10/13 resulted in a denial for a chronic pain management program as the patient was noted to have had an injury for greater than 24 months and no compelling rationale was submitted indicating an exception to the guidelines.

The utilization review dated 04/23/13 resulted in a denial for the chronic pain management program as no objective functional deficits were noted that would warrant the need for an inclusion into a chronic pain program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The documentation submitted for review elaborates the patient complaining of cervical region pain. A chronic pain management program would be indicated provided the patient meets specific criteria to include objective functional deficits noted by clinical exam that would be addressed in a multi-disciplinary setting and all negative predictors of success are identified. There is a lack of information regarding the patient's significant functional deficits related to the cervical region. Additionally, the patient's date of injury is noted to be outside of the 24 month window as 25 months have passed since the patient's date of injury. Given that no information was submitted regarding the patient's significant functional deficits that would clearly benefit from a multi-disciplinary approach and taking into account the patient's 24 month history of being disabled, this request is not indicated. As such, it is the opinion of this reviewer that the request for a chronic pain management program 5 x a 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:

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES