

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410
Austin, TX 78704
Phone: (512) 772-1863
Fax: (512) 857-1245
Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management X 80 hours

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

PM&R 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old male who reported an injury regarding his low back. The patient was noted to have undergone a surgical intervention in the low back. The clinical note dated xxxx details the patient having undergone therapy following the surgical intervention; however, the patient was noted to have ongoing low back pain radiating to the left lower extremity. The patient further stated that he was experiencing numbness in the left lower extremity. The chronic pain management program note dated 01/28/13 details the patient complaining of 7/10 pain. The patient was noted to continue with functional deficits, marked

pain, and sleep disturbance. The patient demonstrated a heavy physical demand level whereas his occupation requires a very heavy physical demand level. The chronic pain management program authorization request dated 02/06/13 indicated no significant changes in the patient's clinical presentation.

The previous utilization review dated 01/31/13 resulted in a denial for 80 hours of chronic pain management secondary to the fact that all other appropriate care options for a chronic pain problem were not ruled out prior to consideration for a chronic pain management program.

The utilization review dated 02/13/13 resulted in a denial for 80 hours of a chronic pain management program secondary to the patient's failure to improve after 10 sessions of a work hardening 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 ongoing low back pain despite a previous surgical intervention. The Official Disability Guidelines recommend inclusion into a chronic pain management program provided the patient meets specific criteria to include significant improvements noted with previous multi-disciplinary programs. There is a lack of information regarding the patient's significant improvements throughout the previously completed work hardening program. Given the lack of significant improvements made with the previous work hardening program, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for 80 additional hours of chronic pain management is not supported as medically necessary and the prior denials are upheld.

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 KNOWLEDGBASE

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)**