

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 80 hours of chronic pain management

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 80 hours of chronic pain management is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 09/20/13, 09/30/13

Office note dated 10/17/13, 06/18/13, 04/04/13

Post injection physical therapy evaluation dated 07/16/13

Request for reconsideration dated 09/25/13

Progress summary dated 09/16/13

Preauthorization request dated 08/06/13

Behavioral evaluation report dated 08/02/13

Functional capacity evaluation dated 08/14/13

Letter dated 10/09/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient lost his footing, slipped and fell to the floor. Treatment to date includes physical therapy and left knee injections. Behavioral evaluation report dated 08/02/13 indicates that BDI is 21 and BAI is 5. Diagnoses are major depression moderate; and pain disorder associated with both psychological factors and a general medical condition. Current medications include Norco, Tramadol, Zanaflex, Ambien and Cymbalta. Functional capacity evaluation dated 08/14/13 indicates that required PDL is heavy and current PDL is medium. Progress note dated 09/16/13 indicates that the patient has completed 80 hours of chronic pain management program to date. BDI decreased from 21 to 10 and BAI from 5 to 2.

Initial request for 80 hours of chronic pain management program was non-certified on 09/20/13 noting that the progress report of 09/16/13 does not clearly establish that the patient

has made progress in terms of objective findings on examination, an improvement in work demand level or a reduction in medication. These are important aspects of the program that need to be improved upon in order to determine extension of this type of program. Request for reconsideration states that PDL increased from light to medium and that use of hydrocodone and Ultram were discontinued. The denial was upheld on appeal dated 09/30/13 noting that the reconsideration documents advancement from light to medium PDL; however, the pre-program functional capacity evaluation identified the worker to function in the medium PDL range. There is no additional clinical information provided and it is not clear the worker continues to require formal interdisciplinary treatment given reduction of BDI from 21 to 10 and BAI from 5 to 2, no change in perceived pain levels compared to the office record of 06/18/13 and no change in functional activity tolerance.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has completed a trial of chronic pain management program without significant progress documented. There is no updated physical examination, functional capacity evaluation or PPE submitted for review to establish objective measures of improvement. The Official Disability Guidelines support up to 160 hours of chronic pain management program with evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. There is no additional clinical information provided to address the issues raised by the initial denials. As such, it is the opinion of the reviewer that the request for 80 hours of chronic pain management 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)