

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours Initial Chronic Pain Management Program for symptoms related to the Lumbar Spine, daily for two weeks

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

Board Certified PM&R
Board Certified 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:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the lumbar spine dated 06/06/12
Initial medical report dated 06/18/12
Clinical report dated 02/11/13
Clinical report dated 02/27/13
Procedure report dated 03/21/13
Clinical report dated 04/17/13
Clinical reports dated 04/25/13 & 06/03/13
Work capacity evaluation dated 01/07/13
Behavioral evaluation dated 07/01/13
Preauthorization request report dated 07/08/13
Request for reconsideration report dated 07/15/13
Subsequent medical report dated 08/06/13
Appeal letter dated 08/16/13
Individual psychotherapy reports dated 08/01/30 – 08/12/30
Prior reviews dated 07/12/13 & 07/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he injured his low back. Per the clinical documentation submitted, the patient was initially placed on work restrictions.

Epidural steroid injections were recommended in February of 2013. This was performed on 03/21/13. The patient reported no significant relief from the epidural steroid injection and recommended lumbar facet joint and medial branch blocks in April of 2013. also recommended further physical therapy or work conditioning. The patient did have a work capacity evaluation completed on 07/01/13 that showed a good validity profile. The patient was noted to have a required heavy physical demand level and tested at a light physical demand level. There was a behavioral evaluation dated 07/01/13 which documented significant pain with moderate findings for depression and anxiety on BDI and BAI testing. The patient's GAF score was 65. It was noted that the patient did have individual psychotherapy; however, it is unclear when this was performed as the date appears to be a typo. The patient's psychological evaluation did not include MMPI2 or BHI2 testing for validity. Per the preauthorization request from 07/08/13, the patient did utilize previous medications including Ultram, Flexeril, Motrin, and Cymbalta. Due to fear avoidance behaviors, the patient was recommended for a 10 day chronic pain management program. Further information on 08/06/13 indicated that medial branch blocks were denied. There were also no recommendations for surgery.

The request for a chronic pain management program for 10 sessions 80 hours was denied by utilization review on 07/12/13 due to the lack of documentation regarding any pertinent psychological issues or the concurrent use of analgesics and neuromodulators. The patient did not describe indicators of problems with household maintenance, sleep control, weight loss, hygiene maintenance, or loss of socialization skills.

The request was again denied by utilization review on 07/23/13 as there was no indication of chronic use of narcotics or any indications that self-supportive treatment would not be appropriate.

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

The patient has been followed for ongoing complaints of low back pain. Based on review of the clinical documentation, the patient has been provided previous medications and underwent 1 epidural steroid injection in March of 2013 with no response. There were further recommendations for interventional treatment to include medial branch blocks. However, this has not been performed to date. There is no documentation to establish that the patient failed to improve with standard physical therapy or work conditioning as recommended in the clinical documentation submitted for review. Per current evidence based guidelines, patients are recommended to have exhausted all lower levels of care before considering a chronic pain management program. Furthermore, it is unclear whether the patient has been maximized on medications to include psychotropic medications. The patient's behavioral evaluation did report evidence of depression and anxiety; however, there were no validity measurements provided with the evaluation to support the patient's self-reporting regarding depression or anxiety symptoms. Given that there is no documentation to establish that the patient has reasonably exhausted conservative treatment prior to a chronic pain management program and as the behavioral evaluation provided for review was limited due to the lack of validity testing, it is this reviewer's opinion that medical necessity for the chronic pain management program has not been established 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 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)