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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/10/2014

IRO CASE #:

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

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:

[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. It is the opinion of the reviewer that the request for chronic pain management program 80 hours is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. PPE dated 02/13/14 indicates that required PDL is heavy and current PDL is sedentary light. Request for services dated 02/20/14 indicates that the patient has completed approved sessions of group psychotherapy and physical therapy, but was noted to make minimal progress. BDI is 29 and BAI is 14. FABQ-W is 42 and FABQ-PA is 24. Medications are listed as Norco, Zanaflex, Lyrica. Evaluation summary indicates that treatment to date includes medication management, physical therapy, lumbar epidural steroid injections, lumbar facet block and RFTC.

Initial request for chronic pain management program x 80 hours was non-certified on 03/04/14 noting that the length of time that the claimant is removed from the onset of symptoms would be considered a negative predictor for significant benefit from such an extensive program. Request for reconsideration dated 03/12/14 indicates that the patient has exhausted lower levels of care and is pending no additional procedures. The denial was upheld on appeal dated 03/14/14 noting that according to note from 02/10/14, it does not appear claimant has had a complete medical therapy course including surgical consideration given the nerve root compression documented on MRI. There is no indication that the claimant has refused surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xxxx; however, the mechanism of injury is not described. The Official Disability Guidelines generally do not recommend chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There are no treatment records submitted for review. As such, it is the opinion of the reviewer that the request for chronic pain management program 80 hours 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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)