Notice of Independent Review Decision - WC

DATE OF REVIEW:

01/27/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 5 Sessions x 2 Weeks

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

Board Certified in Physical Medicine & Rehabilitation

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 or not medical necessity exists for each of the health care services in dispute.

Chronic Pain Management 5 Sessions x 2 Weeks – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Mental Health Evaluation, 08/29/13
- Functional Capacity Evaluation, Unknown Provider, 08/29/13
- Individual Treatment Plan, 11/01/13
- Handwritten Note, 11/01/13, 12/02/13
- 30 Day Follow Up to Initial Mental Health Evaluation, 11/05/13
- Non-Certification Letters, 11/11/13, 01/06/14
- Appeal Letter, 11/11/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as xx/xx/xx. It was documented on the date of injury that the patient was at work and was assaulted by a fellow employee. The individual who assaulted the patient struck the claimant in the right ribcage region.

The patient received a mental health evaluation on 08/29/13. On that date, it was documented that the patient was on the following prescription medications: Lunesta and clonazepam. Pain symptoms were described as 6/10. It was recommended that the patient receive access to treatment in the form of individual counseling services.

A Functional Capacity Evaluation (FCE) was accomplished on 08/29/13. The assessment revealed that the patient was capable of sedentary work activities.

A mental health evaluation was accomplished on 11/05/13. On this date, it was documented that the patient had received ten sessions of individual counseling. It was documented that he was on the following prescription medications: Lunesta, clonazepam, and Lexapro. It was recommended that consideration be given for treatment in the form of a comprehensive pain management program.

The claimant was evaluated on 12/02/13. On that date, the patient was provided a prescription for Lexapro. The pain was described as 4/10.

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

Based upon the medical documentation currently available for review, the Official Disability Guidelines would not presently support a medical necessity for treatment in the form of a comprehensive pain management program. The records available for review do not provide specifics as it relates to what type of lower levels of care have been provided. It is documented that the patient has received access to individual counseling services, but specifics are not provided with respect to what type of conservative treatment was previously provided to the patient in the form of physical therapy and/or therapeutic injections. Additionally, there are no specifics provided with regard to what type of diagnostic testing has previously been accomplished to determine if there an indication for a specific type of treatment that could significantly resolve symptoms. The records available for review do not provide documentation to indicate that an invasive procedure has definitely been ruled out as a means of treating the patient with respect to the documented symptoms of right ribcage pain. As a result, based upon the records available for review, medical necessity for consideration of treatment in the form of a comprehensive pain management program is currently not established per the criteria set forth by the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☒ **DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**