



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision
Amended and Sent on 6/17/2014

DATE OF REVIEW: 5/21/2014

Date of Amended Decision: 6/17/2014

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Chronic Pain Management Program 80 hours/unit.

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

M.D. Board Certified in Physical Medicine and Rehabilitation and Pain Management.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was involved in an accident on xx/xx/xx. He has had neck and low back pain. He had physical therapy, a work hardening program and ESIs. He has been on Naproxen which causes itching. He has been on Ultram, Hydrocodone and Amitriptyline. He has not been able to return to work. His pain is 8/10. His BDI is 22 and BAI is 33. This is a request for trial of chronic pain program.



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

Per ODG references the requested "Outpatient Chronic Pain Management Program 80 hours/unit" is medically necessary.

Chronic pain programs are recommended where there is access to programs with proven successful outcomes, such as decreased pain and medication use, improved function and return to work and decreased utilization of the health care system. There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. The patient should *show evidence of motivation to improve and return to work and meet the selection criteria*. The predictors of failure in a CPP are poor work adjustment and satisfaction, a negative outlook about future employments, high levels of pretreatment depression, pain and disability, increased duration of pre-referral disability time, higher levels of opioid use and elevated pre-treatment levels of pain.

This claimant is appropriate for a chronic pain program. He has failed lower levels of care such as ESIs, medication management and therapy. He continues to have high levels of pain, depression and anxiety.

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

- 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