

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: chronic pain program x 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:

- 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 chronic pain program x 80 hours is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. Treatment to date includes physical therapy, individual psychotherapy, MRI, EMG/NCV, CT scan and medication management. Functional capacity evaluation dated 04/16/14 indicates that required PDL is medium and current PDL is sedentary. Initial behavioral medicine consultation dated 04/25/14 indicates that medications include Celexa, Norco, Soma and Tramadol. Diagnoses are major depressive disorder, and somatic symptom disorder with predominant pain. Psychological testing and assessment report dated 06/20/14 indicates that BDI is 43 and BAI is 27. The patient produced an invalid and uninterpretable MMPI protocol due to reporting a considerably larger than average number of symptoms.

Initial request for chronic pain program x 80 hours was non-certified on 07/03/14 noting that there does not appear to be anything physically wrong with this patient. She simply endorses back pain complaints, yet she has no objectively identifiable pathology to support those pain complaints. The patient appears to have had no treatment since 2011. MMPI produced an invalid and uninterpretable protocol due to reporting a considerably larger than average number of symptoms. Reconsideration dated 07/21/14 indicates that her treating physician has prescribed chronic pain management treatment as warranted and medically necessary. The denial was upheld on appeal dated 07/25/14 noting that she has not had active treatment since 2011. She was denied a work hardening program. There has been no clear recent conservative treatment. The injury is greater than xx months which is a negative predictor of success as per guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xxxx. The Official Disability Guidelines generally do not support chronic pain management programs for patients who have been continuously disabled for greater than xx months as there is conflicting evidence that these programs provide return to work beyond this period. There is no indication that the patient has undergone any recent active treatment. Therefore, the patient has not exhausted lower levels of care as required by the Official Disability Guidelines, and is not an appropriate candidate for this tertiary level program. MMPI produced an invalid and uninterpretable protocol due to reporting a considerably larger than average number of symptoms. As such, it is the opinion of the reviewer that the request for chronic pain program x 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

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)