

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

DATE NOTICE SENT TO ALL PARTIES: Dec/01/2015

IRO CASE #:

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

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

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 this reviewer's opinion that medical necessity for chronic pain management 80 hours has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and has been followed for multiple conditions after stepping off a curb twisting the right ankle. The patient had been followed for chronic pain involving the right lower extremity and was eventually assessed with an incomplete tear at the ATFL of the right ankle on MRI studies. The patient underwent surgical intervention to repair the right ankle in February 2015. Post-operatively the patient attended rehabilitation. Following surgery, the patient did continue seeing for right ankle and foot pain. Patient has been recommended for both a work hardening and chronic pain management program. The most recent clinical assessment was from 08/17/15 which noted stiffness and swelling in the lateral malleolus and arch of the right foot with limited range of motion. There was a functional capacity evaluation dated 10/28/15 which noted moderate limitations in range of motion at the right ankle with minimal limitations in regards to strength. The patient's demonstrated physical demand level was median was medium while his required physical demand level was very heavy. The requested 80 hours of chronic pain management was denied on 10/27/15 as there was an extended period of time from the date of injury to the current timeframe which would be a negative predictor for positive response to a chronic pain management program. The request was again denied on 11/04/15 as the records did not indicate the patient had currently been able to return to work and was only able to perform sedentary work eight years after the injury and only with massive doses of pain medications. It is noted that the reviewer offered a modification of the request however this was declined.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical assessments provided for review would not support the requested chronic pain management program as medically necessary. Although a recent functional capacity evaluation did not demonstrate the patient's ability to perform at a very heavy physical demand level which was required for the patient to return to his original occupation, there were no other multidisciplinary assessments recently performed for this patient as recommended by current evidence based guidelines. There was no indication the patient had failed other conservative management at lower levels to

include a work conditioning program. Given the patient's date of injury, which is now more than xxxxx, this is a significant negative predictor for success through a chronic pain management program per guidelines. Given these above noted issues which have not been addressed by the clinical documentation submitted for review, it is this reviewer's opinion that medical necessity for chronic pain management 80 hours has not been established and the prior denials remain 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)