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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/23/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:
Physical Medicine And Rehab

Description of the service or services in dispute:
Referral to Pain Management Specialist

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)

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 05/07/15, a utilization review determination for the initial request for a pain management referral was submitted noting the patient was currently receiving supervised therapy, and had been previously treated with medications and had an ortho consult and the request did not appear to be medically necessary. On 05/22/15, an adverse determination letter was submitted for the requested pain management referral noting there was no evidence that the patient had failed to respond to conservative measures already provided to date, and there was insufficient information provided to warrant the current request as it related to the initial work injury. The recommendation was for non-certification.

Guidelines state that referrals such as this are based on medical necessity. The records indicate the patient had sustained an injury, and in all most likelihood had resolved that injury. The most recent exams reveal that he has a slight difficulty with his gait but he is neurologically intact objectively. He has areas of hypoesthesia within the dermatomes at L5 on the right not consistent with MRI as the MRI shows no acute osseous lesions and the discs, spinal contents and paraspinal structures are considered normal. Due to inconsistencies and lack of significant objective evidence, it is the recommendation of this reviewer that the request for a referral to a pain management specialist is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain

- [ ] Interqual Criteria
- [x] Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- [ ] standards Mercy Center Consensus Conference Guidelines
- [ ] Milliman Care Guidelines
- [x] ODG-Official Disability Guidelines and Treatment
- [ ] Guidelines Pressley Reed, the Medical Disability Advisor
- [ ] Texas Guidelines for Chiropractic Quality Assurance and Practice
- [ ] Parameters Texas TACADA Guidelines
- [ ] TMF Screening Criteria Manual
- [ ] Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- [ ] Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)