DATE OF REVIEW: 08/20/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic Pain Program x 10 Sessions – 80 Units 3x Week - 97799

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pan 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 or not medical necessity exists for each of the health care services in dispute:

- Chronic Pain Program x 10 Sessions – 80 Units 3x Week – 97799 - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a XXXX. XXXX reports XXXX. XXXX has received conservative treatment to include medications, physical therapy, x-rays, MRI, Phycological eval, FCE and orthopedic eval that determined XXXX is not a surgical candidate. Most recent diagnoses include cervical sprain, thoracic back sprain, lumbar sprain, fall, protruded cervical disc, and protruded lumbar disc. Claimant is currently not working. At this time, the treating physician has requested a Chronic Pain Program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The patient does not meet the ODG established criteria for participation in a Chronic Pain Management Program. The ODG specifically states that an adequate multidisciplinary evaluation must be performed. Review of the FCE done in conjunction with the evaluation indicated

widespread inconsistencies in effort and participation. As the patient was able to achieve medium PDL and needs to be at heavy PDL prior to full duty return, the inconsistent FCE does not suffice as adequate and there is insufficient evidence to support medical necessity of the requested treatment. Therefore, the requested treatment is determined to not be medically necessary at this time.

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

☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

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