True Resolutions Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #624
Mansfield, TX 76063
Phone: (512) 501-3856
Fax: (888) 415-9586
Email: manager@trueresolutionsiro.com

Date: 8/17/2018 4:05:13 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
10 additional chronic pain management programs, 10 total days at 8 hours daily, for the management of symptoms related to bilateral hands/wrists and elbows injury.

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as the patient was preparing documents while performing XXXX work duties when XXXX began to experience forearm and wrist pain. The current diagnoses were documented as carpal tunnel syndrome of the bilateral upper limbs, other synovitis and tenosynovitis of the right and left forearm and right and left hand as well as lateral epicondylitis of the right and left elbow. It was noted that as of XXXX that the patient was participating in a chronic pain management program which had improved XXXX mood and anxiety as well as achieving improvements in activities of daily living. The document stated that although the patient reported high levels of pain, XXXX also noted functional improvement from the procedures and therapy sessions. Chronic pain management program behavioral clinical update dated XXXX stating that the patient's scores had fluctuated when compared to XXXX previous results. The waxing and waning of XXXX scores suggested that XXXX recovery had not yet reached a plateau and further meaningful recovery was anticipated. The patient was being recommended for an additional 80 hours of chronic pain management at that time. The disabilities of the arm, shoulder and hand report dated XXXX identify the patient continued to have moderate to severe difficulties and inability to perform certain activities. The functional capacity evaluation completed on XXXX identify that the patient's required job physical demand level was 20 pounds or light the patient's current physical demand level at the time of XXXX assessment at 25 pounds also described as light. The visit/SOAP note dated XXXX indicated the patient had completed 10 sessions of chronic pain management program. The patient felt XXXX

was improving with the program but continued to report tenderness during range of motion of XXXX wrist. XXXX describes XXXX pain is severe, sharp, stabbing with numbness with XXXX pain level varying from moderate to severe. Objectively, the patient had positive Phalen's sign in both wrists with numbness and tingling during the testing. The patient's functional capacity evaluation was reference from XXXX which indicated that the patient's left wrist and left elbow had adequate range of motion and XXXX was able to lift XXXX required job physical demand level. However, the right wrist had not been included in the claim and the patient continued to have some issues. XXXX reported pain during active range of motion of both hands and wrists and not reached emotional stable status with continued difficulty pertaining to coping skills. The physician was recommending 10 additional sessions of chronic pain management to help with the patient's emotional issues. The request was denied on XXXX with the rationale stating that notes provided for the patient in the second half of the chronic pain management program were discouraging. The psychological testing did not demonstrate any improvement with the patient having achieved left wrist functional status and allow XXXX to do XXXX job. There was no compelling objective data that would merit continuation in the program. On XXXX, the patient submitted an appeal for chronic pain management program. The physician claims the patient had objective goals of decreased pain, inflammation and muscle spasms as well as medication use and provide XXXX dependence with improved range of motion, strength and functionality. The physician stated that the patient did have improvement on XXXX psychological testing. As per official disability guidelines, and patient may get worse before improving in a functional restoration program. Additionally, the patient had in fact improved in physical capacity, but this was not XXXX only issue. The patient also had a dyspnea to Dr. evaluation on XXXX indicating that and his professional opinion, the patient was not at maximum medical improvement as XXXX had not exhausted options as outlined by the guidelines to include additional sessions in a chronic pain management program. Request was again denied on XXXX. The rationale stated that the patient did not have a clear etiology for continued complaints of wrist, elbow, and upper extremity pain, by definition, the validity of the functional capacity evaluation performed on XXXX was/is suspect. The guidelines also simulate that treatment is not suggested for longer than 2 weeks without evidence of significant demonstrated gains. However, the patient's psychologist stated that the patient remained severely depressed, despite 80 hours of prior treatment to the program in question. It did not appear, short, that previous treatment had proven beneficial, nor did it appear likely that the patient cannot stand to gain from the continuation from the same. This request pertains to 10 additional chronic pain management program sessions for the bilateral hands/wrists and elbows injury.

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

According to the Official Disability Guidelines, treatment within a chronic pain management program is not suggested for more than 2 weeks without evidence of compliance and significant demonstrated efficacy as talkative by subjective and objective gains. The guidelines also state that total treatment duration should generally not exceed 4 weeks (24 days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. Furthermore, if treatment duration more than 4 weeks is required, a clear rationale for the specified extension and reasonable goals to BE achieved should be provided. In the case of this patient, the physician stated that the patient had made sufficient gains in terms of XXXX physical deficits but had not reached maximum medical improvement as of XXXX.

However, the patient was already at XXXX required physical demand level as of XXXX as per the functional capacity evaluation. Furthermore, the evaluation stated that the patient was still showing signs and symptoms of significant depression, indicating that XXXX may have not achieved sufficient improvement in this area of concern. It was also noted that the patient had sufficient improvements in XXXX left upper extremity as related to XXXX abilities to complete XXXX job requirements. Given that the request pertains to both upper extremities, there was no need for the patient to receive additional chronic pain management program care for the left hand, wrist or elbow. It was unclear why the patient could not continue with a home exercise program to address any remaining deficits in the right upper extremity, and no indication regarding how the patient has responded favorably in terms of psychological impairments given XXXX extensive treatment within the chronic pain management program.
As such, in accordance with the previous denial, the request for 10 additional chronic pain management programs, 10 total days at 8 hours daily, for the management of symptoms related to bilateral hands/wrists and elbows injury is not medically necessary. The prior determination is upheld.

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

Official Disability Guidelines (ODG), Treatment Index, 15th Edition (web), 2018, Pain Chapter, Chronic pain programs (functional restoration programs). Criteria for the general use of multidisciplinary pain management programs: