Medical Assessments, Inc.

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March 4, 2018 Amended June 20, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Program, per hour XXXX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Anesthesiology with over 10 years of experience, including Pain Management

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, when XXXX. The claimant was diagnosed with a lumbar sprain.

XXXX: Office visit by **XXXX**. Claimant was seen with new injury to left leg. XXXX stated the pain was unbearable to even upset XXXX stomach. Pain level reported 10/10.

XXXX: Electrodiagnostic Nerve Conduction Study by **XXXX**. Interpretation: This nerve study and EMG is abnormal with findings which are consistent with acute denervation in the left medial gastroenemius, and a left L5-S1 radicular injury.

XXXX: MRI lumbar spine interpreted by **XXXX**. Conclusion: Disc herniation at L5-S1 with spinal and foraminal stenosis. Mild disc bulge at L4-L5 with mild spinal and foraminal stenosis.

XXXX: Office visit by **XXXX**. Reported pain level 6/10. XXXX helping. No PT yet but looking on line and found some stretches which helped. Plan: Start **XXXX**.

XXXX: Office visit by **XXXX**. Claimant was seen for follow up for knee strain. Claimant reported XXXX is feeling much better. Pain is moderate, currently 4/10.

XXXX: Office visit by **XXXX**. Claimant reported pain 2/10, mostly in the back of left thigh and lateral aspect of left calf. Taking **XXXX** twice daily. Takes **XXXX** at night when needed.

XXXX: Office visit by **XXXX**. Claimant was seen for neurologic consultation. The symptoms of pain in the left leg are improved by some 70% since onset. XXXX also had a reduction in a recurrence of low back pain by approximately half. **Assessment:** The claimant's nerve study and EMG today is abnormal with acute denervation noted in the left gastrocnemius muscle.

XXXX: Office visit by **XXXX**. Claimant was seen for follow up. Claimant reported pain level 3/10 and is working light duty. Claimant started **XXXX**.

XXXX: Follow up visit by **XXXX**. Assessment: MRI scan of the lumbar spine is reviews. There is evidence of a disc herniation at L5-S1 to the left with resultant foraminal stenosis and some impingement of the exiting nerve root at that level. Claimant has had a course of antiflammatory agents as well as PT, but continues to have significant symptoms.

XXXX: Office visit by **XXXX**. Claimant reported pain level 2/10. Claimant needed refills of rx.

XXXX: Office visit by **XXXX**. Claimant reported pain level 4/10.

XXXX: Office visit by **XXXX**. Claimant reported pain level 7/10. Claimant is off duty.

XXXX: Progress note by **XXXX**. Lumbar epidural injection at L5-S1 diagnostic with sedation.

XXXX: Rationale for denial: **XXXX**. Rationale for denial: Claimant has some PT and injections. Is still having leg pain and needs to return to work. Psych eval catalogs numerous emotional issues insomnia, sadness, irritability, decreased libido, ect. Only med taking is **XXXX** and XXXX is not taking any psychotropic medications. Pain 4, on average. Determination- non authorized.

XXXX: Rationale for denial: XXXX. Rationale for denial**:** The claimant is a XXXX who was injured on XXXX, when XXXX. The claimant was diagnosed with a lumbar sprain. Treatment included ESI and 12 PT sessions. Medication included **XXXX**. Determinations: Non-authorized.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant is a XXXX who was injured on XXXX, when XXXX. The claimant was diagnosed with a lumbar sprain. Treatment included ESI and 12 PT sessions. Medication included XXXX. This diagnosis does not justify a chronic pain program. Therefore, this request is non-certified.

The request for Chronic Pain Program, per hour XXXX is found to be not medically necessary.

ODG Guidelines:
XX

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

☐ **ACOEM- AMERICAN 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)**