Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

July 23, 2018
IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management program x 160 hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Physician in Family Medicine with over 18 years of experience

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 with a date of injury of XX. The claimant was carrying a XX into XX and struck XX XX with XX causing the right elbow to strike XX and the XX struck the inside of the right elbow. Current diagnosis included right elbow cubital tunnel syndrome and chronic regional pain syndrome.

XX: Functional Capacity Evaluation by XX, FNP-C, D.C. The evaluation was deemed valid and reveals that the claimant did not qualify for the previous job's physical demand level of sedentary-light. The claimant is XX who works as a XX but also had to XX. However, the claimant's position is no longer available and the chronic pain management program is recommended to increase the physical demand level to return to work in another occupation of equal or greater physical demand level.

XX: Mental Health Status Evaluation by XX. Reveals that the claimant presents with significant psychological factors that are barriers to recovery. The BDI score is 38, the BAI score is 25, the FABQ score are 20 on work scale and 36 on physical activity scale. The PAIRS score is 80, the P-3 depression score is 52, anxiety 50 and somatization 60. The psychological provider recommends a chronic pain management program to combat maladaptive behaviors, reduce fear and decreased dependency on medical providers.

XX: Office visit by XX, NP.
XX: UR performed by XX, MD. Rationale for denial: The claimant present with a history of right cubital tunnel syndrome due to reported injury in XX and subsequently reported a development of chronic regional pain

syndrome. Based upon the information submitted for clinical review, the medical necessity of an additional comprehensive treatment program in the form of the requested chronic pain management program is not established.

XX: UR performed by XX MD. Rationale for denial: Based on the clinical information provided, the appeal request for chronic pain management program x 160 hours is not recommended as medically necessary.

XX: Office visit by XX, NP. Medications: XX 10mg, XX XX 031 mg, XX 60mg, XX 1mg, XX 600mg, XX 4mg, XX 150mg, XX 1000 mg, XX 40mg, XX 100mg, XX. Claimant reported pain has gotten progressively worse. XX followed up with XX pain management physician whom did additional programming on XX spinal chord stimulator. XX noted 20% improvement with the changes.

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

The denial of a chronic pain management program is upheld. Based on the information provided, a program of XX is seen as excessive and not medically necessary by clinical guidelines. Clinical data to support the efficacy of such a program has not been verified.

The request for Chronic Pain Management program x 160 hours is found to be not medically necessary**.**

ODG: Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond XX and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated

instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

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)**