AMENDED REPORT 1/24/2019

Date notice sent to all parties: 1/24/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of XX sessions / (XX) units of chronic pain management program XX per week.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgeon.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of XX sessions / (XX) units of chronic pain management program XX per week.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX-year-old XX who was injured on XX, when the XX went down onto XX. An unspecified surgery was performed in XX, with post-operative physical therapy XX times a week for XX weeks beginning XX weeks post-operatively. Medications included XX, XX, XX, XX, XX, XX, XX. An evaluation by behavioral health was performed for possible chronic pain management on XX. There was a XX score of 9 and XX of 14. An evaluation on XX, documented the surgeon recommended additional XX. This was declined by the claimant. Pain management was requested by the claimant. Treatment included XX injection

and XX physical therapy sessions. A Functional Capacity Evaluation indicated the claimant met a medium physical demand level.

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

Objective documentation of a requirement for pain medication which may result in tolerance, dependence, or abuse was not noted. There was no documentation of an absence of additional options to likely result in significant clinical improvement. The claimant was offered surgery and declined. The records do not reflect failure of formal physical therapy. The claimant had initial improvement in the physical therapy to date. The request for XX sessions (XX units) of chronic pain management program XX times a week is not medically necessary.

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)**