True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 2/14/2019 5:32:05 PM CST

True Decisions Inc.

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IRO REVIEWER REPORT

Date: 2/14/2019 5:32:05 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX sessions, XX hours a day, multidisciplinary pain management service

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine, Physical Medicine & Rehab

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]: XX. XX XX is a XX-year-old XX who was injured on XX. XX. XX reported that XX XX to XX XX XX from a XX XX when XX XX XX from about XX XX from the XX XX XX to a XX XX on XX XX XX. XX had been taken to a local emergency room and then flown out to XX XX in XX XX due to XX injuries. XX had sustained a fracture of XX XX and XX XX. XX had been seen by XX. XX, orthopedics and had surgery on XX. XX underwent an XX XX XX XX (XX) of the XX XX. XX had been prescribed at the XX XX (XX) office for XX as well as XX. On XX, XX. XX was evaluated by XX, XX for follow-up of chronic XX XX pain and XX XX pain. The XX XX pain and XX XX joint pain started on XX. XX reported a pain level of 6/10. XX had been denied additional sessions of program; however, XX was in the process of appealing. XX stated that the XX to XX XX had diminished some. XX continued to have some XX. XX was very concerned about XX future, felt XX sometimes because XX might never XX again or do activities. At times, XX did feel XX because XX could not work and was worried if this condition would worsen in the future. XX complained of pain radiating down XX XX XX with numbness and felt heaviness in XX XX XX. XX was on XX, XX, XX, and over-the-counter XX. On examination, XX had

limited ambulation. XX was ambulating with a slight XX to the XX lower XX. XX, XX was XX and XX. XX had abnormal XX, limited range of motion of the XX XX due to pain with internal and external rotation. XX was ambulating with no external assistance. XX tendon reflexes were slightly sluggish and diminished at 2+/4. XX XX and XX XX reflexes were diminished to 1. Mild sensory deficits noted to the XX XX extremity. XX had decreased sensation on the XX XX XX and XX of the XX (XX) and decreased sensation on the sole of the XX and the posterior XX (XX). Mild sensory deficits were noted to the XX lower extremity. Straight XX raise on the XX was 60 degrees with pain elicited. Seated straight XX raise test was positive on the XX. There was XX noted over the XX XX area at the XX. There was XX over XX XX XX, which extended about XX inches above XX XX. XX range of motion was mildly painful. XX XX examination revealed tenderness of the XX process, XX ligament, the XX region at XX, the XX region, and the XX XX. There was tenderness over the XX lower XX region with noted XX. The XX was well-healed and mildly tender. XX lateral flexion to the XX was 45 degrees and to the XX was 10 degrees. XX rotation to the XX was 25 degrees and to the XX was 20 degrees. Flexion was 45 degrees and extension was 10 degrees. There was tenderness over the XX XX XX with limited range of motion. The strength of XX was 4/5 in XX flexion, XX was 4/5 in XX extension, XX anterior was 4/5 in XX XX, and extensor XX XX strength was 4/5 in great XX extension. On XX, XX, XX performed a physical performance evaluation. At the time, XX. XX was functioning at a medium physical demand level (PDL) and XX position required to be at a heavy PDL. XX had been able to adopt a variety of techniques to improve XX level of functioning. Even though XX had been making good progress, XX continued to require additional treatment to help XX more effectively manage the pain symptoms, emotional distress, and difficulty adjusting to change and loss associated to both XX factors and a general medical condition and acquire the level of recovery and stability needed to improve and maintain XX level of functioning. It was not uncommon for patients, like XX. XX, to participate in additional sessions after successfully completing first trial of MCPM treatment with evidence of compliance and who demonstrate significant efficacy as documented by subjective and objective gains to request another XX sessions. It was important not to interrupt the momentum in XX treatment. Treatment to date consisted of medications (XX, XX, XX, XX, XX), XX therapy, surgical intervention (open reduction and internal fixation of the XX XX). A request for reconsideration for multidisciplinary XX chronic pain management services was made by XX. XX on XX. As request for, additional XX sessions for XX. XX was recently requested and formal preauthorization request was entered. However, the request was denied. It was documented that XX. XX XX stated, “There is no indication that the injured worker has been prescribed and failed adequate trials of a XX or an XX XX XX XX such as XX or XX". Per a utilization review dated XX, the request for XX sessions, XX hours a day, multidisciplinary pain management service between XX and XX was non-certified by XX. Rationale: “I spoke with XX. XX at XX:XX XX XX on XX. XX reports injured worker is status post chronic pain management sessions x XX sessions. XX has met XX PDL requirements to return to work except needing to lift XX XX and currently able to lift XX XX. XX is knowledgeable with HEP. XX is off XX XX medication. Therefore, I have not changed my opinion due to there are no significant current functional barriers to allow improved lifting strength from XX XX to XX XX with the ongoing use of XX HEP. In my judgment, the clinical information provided does not establish the medical necessity of this request. Based upon the available documentation and noted guidelines, I do not recommend approval for the requested services as reasonable or medically necessary. Documentation indicates past multidisciplinary pain management treatment of XX sessions has been utilized. Recent sessions of the multidisciplinary program have not reported significant measured functional gains to support additional treatment sessions. As such the request for XX sessions, XX hours a day, multidisciplinary pain management service is not medically necessary.”

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

Based on the clinical information provided, the request for XX sessions, XX hours a day, multidisciplinary pain management service is not recommended as medically necessary, and the previous denials are upheld. A request for reconsideration for multidisciplinary behavioral chronic pain management services was made by XX. XX on XX. As request for, additional XX sessions for XX. XX was recently requested and formal preauthorization request was

entered. However, the request was denied. It was documented that XX. XX stated, “There is no indication that the injured worker has been prescribed and failed adequate trials of a TCA or an SNRI XX XX XX adjuvant such as XX or XX". Per a utilization review dated XX, the request for XX sessions, XX hours a day, multidisciplinary pain management service between XX and XX was non-certified by XX, XX. Rationale: “I spoke with XX. XX at XX:XX XX XX on XX. XX reports injured worker is status post chronic pain management sessions x XX sessions. XX has met XX PDL requirements to return to work except needing to lift XX pounds and currently able to lift XX pounds. XX is knowledgeable with HEP. XX is off XX XX medication. Therefore, I have not changed my opinion due to there are no significant current functional barriers to allow improved lifting strength from XX XX to XX XX with the ongoing use of XX HEP. In my judgment, the clinical information provided does not establish the medical necessity of this request. Based upon the available documentation and noted guidelines, I do not recommend approval for the requested services as reasonable or medically necessary. Documentation indicates past multidisciplinary pain management treatment of XX sessions has been utilized. Recent sessions of the multidisciplinary program have not reported significant measured functional gains to support additional treatment sessions. As such the request for XX sessions, XX hours a day, multidisciplinary pain management service is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that total treatment duration should generally not exceed XX full days/XX hours of the program. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. It is reported that extenuating circumstances to support exceeding this recommendation include the patient’s decision not to pursue surgical intervention and significant emotional distress. However, the guidelines acknowledge that in many cases, the goal of treatment is to prevent or avoid surgery. Additionally, this multidisciplinary program would not be appropriate if a patient did not have a XX component to their injury as there is a significant XX treatment component to the program.

Therefore, given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence based guidelines and the decision 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

Chronic pain programs (functional restoration programs)