US Decisions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

Chronic pain program additional XX sessions / XX units XX times a week

XX Unlisted XX medicine/rehabilitation service or procedure

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Anesthesiology

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- [x] Overturned (Disagree)
- [ ] Upheld (Agree)
- [ ] Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. XX. XX was XX a XX into XX, when the XX XX, and all the XX XX XX XX on XX. XX, who was XX XX the XX and the XX. The ongoing diagnoses included strain of muscle, XX, and tendon at XX level, subsequent encounter (XX.XX).

XX. XX underwent a functional capacity evaluation (FCE) on XX. The purpose of the evaluation was to determine the overall XX and functional abilities. XX stated that XX needed to transition from sitting, standing, and walking throughout the day to deal with the pain in the XX, XX, and XX XX. XX did not meet XX job demands on the repetitive kneeling assessment and the above-the-XX assessment. XX was able to raise XX XX XX at about 50% and the XX XX at a 70% angle. Many self-limiting behaviors were seen throughout the non-material-handling exercises. Sustained squatting was terminated due to mechanical deficits, increased pain, and safety concerns. During the prolonged walking assessment, XX stated that XX felt constant burning and tingling in XX XX XX and preferred not to hold onto the XX from the XX, instead XX held the XX XX. XX. XX demonstrated the ability to perform within the sedentary physical demand category, whereas XX job as a XX XX was classified within the heavy physical demand category.

XX. XX was seen by XX, XX on XX for XX XX pain and XX pain. The pain was described as constant, aching, sore, burning, and constant, rated at 7-9/10. Generally, XX felt that XX was doing better in the program, but continued to have a lot of XX pain. XX was able to stand / sit / walk for less than XX minutes. On examination, straight XX raise was positive XX. the diagnoses were strain of muscle, XX, and tendon of lower XX, initial encounter; and strain of muscle, XX, and tendon at XX level, subsequent encounter.

Per an office visit dated XX by XX, XX, XX. XX presented for a follow-up of XX, low XX, and XX XX. The XX pain was located in the posterior XX XX. The symptoms were described as frequent, sharp, and moderate. The pain radiated to the XX XX and XX XX. The associated symptoms included XX tenderness, decreased range of motion, and XX muscle spasm. The aggravating factors included XX movement. The relieving factors included medications and XX therapy. The XX XX symptoms were improving slowly. XX had XX XX XX pain, which radiated to the XX XX. The pain was described as sharp and moderate. The symptoms were associated with decreased range of motion. The exacerbating factors were twisting, lifting, and bending. The relieving factors included medications and XX therapy. XX. XX disagreed with 0% impairment rating (IR) by designated doctor examination (DDE) and was requesting an

alternate IR. On examination, a mildly guarded gait was noted. The XX XX examination showed tenderness in the XX groove and in the XX. There was limited range of motion in all planes. On examination of the XX XX, XX had tenderness in the XX XX (XX, XX, XX, XX, and XX). Palpation revealed XX muscle spasm. There was limited range of motion and XX of the XX XX. XX alignment exhibited a loss of normal XX. XX had tenderness in the XX XX (XX, XX, XX, and XX). Palpation revealed XX muscle spasm. XX had limited range of motion and paresthesia of the XX XX. XX commented that XX. XX had significant difficulties with the physical requirement of XX job.

The treatment to date included medications (XX, XX, XX, nonsteroidal anti-inflammatory drugs, and anti-inflammatory creams), XX epidural steroid injection at XX-XX on XX, XX therapy, XX sessions of chronic pain program.

Per a utilization review decision letter dated XX and a peer review dated XX, the request for additional XX sessions / XX units of the chronic pain program was denied by XX, XX as not medically necessary. Rationale: "The claimant has had XX sessions with an indication of change in medication usage, minimal changes in XX scores, an increase in XX overall pain score, and minimal improvement in physical function. Given the overall minimal progress thus far after the XX hours of a comprehensive pain program, there is no support to continue with this line of treatment. Therefore, the request for Additional Chronic Pain Program XX sessions / XX units (XX a week) is not medically necessary." The poorly scanned medical records were partially legible.

An appeal letter was written by XX, XX / XX, XX on XX documenting that the reviewer denied XX. XX's additional Chronic Pain Management Program (CPMP) sessions due to the pain level increased slightly. In the progress notes, it was stated that XX. XX's pain level went up due to massage therapy, but that XX then got better as noted on the progress summary regarding XX range of motion and looking at the massage therapy notes. XX doubled the weight XX was pushing and pulling as per XX progress summary dated XX. XX began time on the treadmill for XX minutes and was doing XX minutes at the time of the progress summary. XX had voiced that XX was getting better and wanted to return to work. Allowing XX XX additional sessions under Official Disability Guidelines (ODG) was recommended, since XX had shown improvement from the beginning.

Per a utilization review decision letter dated XX and a peer review dated XX, the prior denial was upheld by XX, XX. Rationale: "Appeal Additional Chronic Pain Program XX sessions / XX units (XX a week) is not medically necessary. Though the patient had prior sessions of XX hours of comprehensive pain program, the patient had sessions with minimal change in medication usage, XX score with minimal improvement in physical function. As such, the request is not medically necessary." The inadequately scanned medical records were partially legible.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Patient is currently completing a CPMP, and provider has requested XX additional sessions to focus on internalization of pain XX XX, XX XX changes in XX of pain and healing. Progress report dated XX describes several XX improvements; VAS still 6, going up with massage therapy; patient exhibits learning of XX, XX skills, and physical conditioning. XX has not reached XX physical goals yet, but has exhibited a commitment and interest in the program.

Two prior reviews tended to focus only on the VAS score and medication usage, citing minimal progress. However, after reviewing the detailed 8-page progress report, this reviewer concludes that the patient has demonstrated the requisite progress, and needs program continuation (additional sessions) to complete therapy and finalize goal achievement. Given the documentation available, the requested service(s) is considered medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine

- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low XX Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)
  XX

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.