

# IRO Express Inc.

An Independent Review Organization

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**DATE OF REVIEW:** March 18, 2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

10 sessions of chronic pain management

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

A Chiropractor with 11 years of treating patients in the Texas Workers' Compensation system as a level II approved treating doctor

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines, Notes from MD dated 9/12/07, notes from MD dated 2/1/08, and notes dated 3/4/08, IRO Position Statement (No date) Patient Profile (No Date) Employee Return to Work Agreement (No date) Pre-Auth Request (No date) Progress Report 2/18/08 and 11/30/07, History of Injury (No Date), Denial Letters (1/17/08 and No date).

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while working as a xxx. She was climbing on the tailgate of a truck and slipped and fell backwards, landing flat on her back and struck her head on the ground, injuring her back and neck.

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

The 10 sessions of chronic pain management are not reasonable or medically necessary according to the below referenced criteria. There appears to be a lack of objective functional goals and inconsistency in the treatment schedule. From the notes provided, there also appears to be a history of a mental condition that has slowed the progress of treatment. It would not be reasonable to expect a positive outcome from the requested 10 sessions of chronic pain management. Therefore, the 10 sessions of chronic pain management are not reasonable or 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)