

- Request for a Review by an Independent Review Organization dated 3/26/10.
- Request for Reconsideration dated 3/19/10, 3/15/10.
- Chronic Pain Management Request Letter dated 3/12/10.
- Patient Report dated xx//xx/xx.
- Pre-Authorization Request dated 3/8/10.
- Mental Health Evaluation dated 3/4/10.
- Work Capacity Evaluation dated 3/4/10.
- Examination Report dated 2/10/10.
- Orthopedic Report dated 6/10/09.
- History/Physical Treatment dated 1/19/10.
- Orthopedic Consultation dated 12/10/09.
- Designated Doctor Evaluation dated 12/1/09.
- Cervical Spine MRI dated 11/30/09.
- Initial Narrative Report dated 8/31/09.
- Range of Motion Exam dated 8/31/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: xx

Date of Injury: xx/xx/xx

Mechanism of Injury: Reaching forward to move a piece of equipment.

Diagnosis: Cervical, thoracic and lumbar sprain/strain.

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

This sustained a work-related injury on xx/xx/xx, involving the cervical, thoracic and lumbar spine while reaching forward to move a piece of equipment. Subsequent to the injury, the claimant's diagnoses were cervical, thoracic and lumbar sprain/strain. He was allowed to return to work with restriction of no lifting over 20 pounds. Treatment rendered from July 2009 to August 2009, consisted of chiropractic care, physical therapy, electrical muscle stimulation, ultrasound, and ice. A cervical MRI, performed on November 3, 2009, revealed 1 to 2 mm disk protrusions at C4-5 through C7-T1 levels without neural foraminal stenosis and/or spinal stenosis. On December 1, 2009, the claimant underwent a designated doctor evaluation which diagnosed the claimant with cervical, thoracic strain, mechanical pain syndrome and lumbar strain (resolved). It was opined that the claimant had reached maximum medical improvement (MMI) with a 0% whole person impairment rating. The treating physician insisted that the claimant suffered from chronic pain with persistent/secondary depression and issues with difficulty coping with his pain. However, this claimant had returned to regular duty at work at a heavy job status or level. A chart review performed on February 20, 2010, by Dr. (orthopedic surgeon) noted that there was no indication for

additional chiropractic treatment, work hardening, work conditioning, chronic pain management, psychological care, a transcutaneous electrical neurostimulation (TENS) unit, or spinal cord stimulation. After a review of the information submitted, the previous adverse determination for 10 sessions of chronic pain management program has been upheld. With the extent of this claimant's injury documented, along with subjective and objective findings, the clinical indication of the request could not be established. The main purposes of chronic pain management programs are to return patients back to work, which the patient had already done. The ODG state, *"Chronic pain programs (functional restoration programs) Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in Delayed recovery. There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient 's pain."* There was no indication that the patient had participated in any type of individual psychotherapy in conjunction with psychotropic medications. Therefore, in accordance with the ODG, there did not appear to be sufficient reason to overturn the prior adverse determination.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Pain - Chronic pain programs (functional restoration programs).

- 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).