



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

## Notice of Independent Review Decision

**DATE OF REVIEW: 2/21/2011**

**IRO CASE #:**

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

**10 Sessions Chronic Pain Management Program.**

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

D.O. whose specialty is **Anesthesiology and Pain Management.**

**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)





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

1. Throughout the clinical documentation, working diagnosis is lumbar sprain/strain. The patient's injury occurred in xxxx, and according to ODG, lumbar strain/sprain diagnosis and treatment is not a covered benefit for more than a 3 to 6 month period. Patient has been treated for almost five years for a condition which should not last more than 6 months.
2. Patient had 25 sessions of physical therapy with no improvement in his condition. In my opinion, if 25 sessions of physical therapy did not show any improvement in his condition, further physical therapy sessions are not warranted.
3. All throughout clinical and psychological evaluation no documentation was noted to support any attempt or motivation by the patient to return work, or to return to any physical activity.
4. According to the patient's psychological evaluation, there was an objective finding of depression and anxiety. In all clinical documentation provided, no note of any antidepressant therapy or group or individual psychotherapy was provided. Again, according to the official disability guidelines, it suggests chronic pain management programs methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to resolve clinical improvement. According to the clinical documentation provided, it does not appear that all lower levels of care were provided (psychological therapy, or antidepressant medication).

**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



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- 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)**