



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

Notice of Independent Review Decision

DATE OF REVIEW: 1/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program: 10 sessions.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

Mr. is a male who was injured on xx/xx/xx while employed with . He tripped over carpet and injured his left knee, head, face, neck and lower back. His compensable injury is low back and left knee allowed by workman's comp. Patient was initially seen and treated by a Chiropractor (Dr.). Subsequently he was referred to Dr. (Orthopedic and Rehab). Patient underwent a complete physical evaluation by Dr., a physical therapy evaluation, a functional capacity evaluation and a mental health evaluation. According to Dr., patient continued to complain of left knee pain and low back pain. Patient was offered surgery for the left knee, which he declined. Patient continued to work throughout this time at a lesser capacity due to pain. According to the FCE, the test was limited to self-reported pain during testing and some reported deficits were identified which would make it unsafe to perform the carrying, lifting and bending test. The results of the mental evaluation revealed 1) pain disorder and 2) major depressive disorder with associated anxiety.

Examination by Dr. showed diagnostic impression as follows:

1. Chronic left knee pain and severe patellofemoral dysfunction with mild deficit and moderated quad atrophy with mild gait disturbance, and imaging shows frayed free edge of lateral meniscus.
2. Chronic left lumbar pain, lumbar MRI showed a finding of L4-5 1.4 mm annular disc bulge which mildly compressed the thecal sac, also some slight foraminal narrowing which was greater on the left than right. Dr. exam of the above patient did report some deficit of the left knee, and some lumbar tenderness on palpation and muscle spasms noted bilaterally throughout.

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

According to the ODG chapter on chronic pain programs (functional restoration programs), outpatient programs are warranted for patients with delayed recovery, which applies to Mr.. Previous methods of treating chronic pain have to have been unsuccessful and with no other non-surgical options which also applies to Mr.. An adequate multidisciplinary evaluation is required. The patient has had a multidisciplinary evaluation in the form of a psychological, physiological, and sociological assessment, which indicates that he continues to have pain, causing depression and anxiety. If a goal of treatment is avoidance of optional surgery

then a trial of 10 visits or 80 hours is warranted. The patient may be able to avoid surgery if the chronic pain program is successful. The criteria require documentation of patient motivation to change. As obtained from the history and clinical notes, the patient continues to be motivated (patient continues to work full time). Based on the criteria outlined in the ODG chapter on chronic pain programs, a chronic pain management program 10 sessions is warranted in in this case.

REFERENCES

ODG chapter on Chronic pain programs (functional restoration programs).

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



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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)**