



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 10/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CHRONIC PAIN MANAGEMENT X 10 SESSIONS

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

M.D. Board Certified in Occupational Medicine.

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)



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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) -Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	9/22/2011
Utilization Review Determinations	8/24/2011-8/29/2011
D.O. Follow up Prescription for Chronic Pain Management Program	5/17/2011
Pre-Authorization Request Request for 10 Days of Chronic Pain Management Interdisciplinary Pain Treatment Components Interdisciplanry Plan & Goals of Treatment	8/22/2011 6/01/2011 5/17/2011
Physical Performance Evaluation	5/17/2011
Initial Mental Health Status Evaluation	1/13/2011
Imaging MRI cervical Spine Report Cervical Trigger Point Injection	8/17/2010 9/30/2010
M.D. Evaluation Report	10/07/2010
Designated Doctor Evaluation	8/17/2011
Texas Department of Insurance Report of Medical Evaluation	8/17/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained work related neck and upper back injury on xx/xx/xxxx while performing her duties assisting a patient when he lost his balance and slammed into her causing her to be knocked to the ground. Since the accident the patient has been experiencing neck and upper back pain (Cervico thoracic myofascial pain). A cervical MRI dated 08/17/2010 revealed 1mm disc bulge at C3-4, broad 1-2mm disc protrusion at C4-5, broad 2mm disc protrusion at C5-6 with a 3mm posterolateral component causing mild left foraminal narrowing. The patient states that she had MRI of her right shoulder with no evidence of abnormalities. She has received conservative treatment to include Physical therapy, nerve blocks and trigger point injections and medications. Current medications include Tramadol, Robaxin, Wellbutrin, Amrix, Metoprolol and Amlodipine. She has been deemed not to be candidate for surgery. She was denied work hardening and was placed at MMI 5/26/11 with 0% IR.

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



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Patient has a diagnosis of Chronic pain syndrome .

According to medical records reviewed she has: 1) excessive dependence on healthcare providers and family to be able to function with ADL 2) she is deconditioned and cannot perform at a medium PDL. 3) She has withdrawn from social activities 4) failure to restore pre injury function 5) has psychological sequelae of depression single episode due to a physical condition 6) Does not have a personality disorder and 7) has switched to OTC medication with increased levels of pain.

Previous methods of treatment have failed.

Adequate multidisciplinary evaluation has been performed to include diagnostics, psychological testing and social vocational issues.

A treatment plan has been presented for participation in a chronic pain program.

She has no substance abuse issues.

Negative predictors of success have been addressed.

She has not been off work over 24 months.

In summary, adequate multidisciplinary evaluations have been made, all diagnostics assessments have been made and she has no other treatment options pending. She is not a surgical candidate.

She therefore qualifies for a trial of 10 sessions of Chronic Pain Program.

REFERENCES

ODG treatment Chronic Pain Programs, Criteria for use of Multidisciplinary pain management program.

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



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- 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: