



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office (MCQA) MC 103-5A
Via E-mail IRODecisions@tdi.state.tx.us
IRODecisions.TITAN@tdi.state.tx.us

DATE OF REVIEW: 1/06/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of Chronic Pain Management Program.

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

M.D. Board Certified in Physical / Rehabilitation Medicine 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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	12/17/2012
IMO	



14785 Preston Road, Suite 550 | Dallas, Texas 75254
 Phone: 214 732 9359 | Fax: 972 980 7836

Adverse Determination Letters	10/29/2012-11/29/2012
Pre-Authorization Request	10/23/2011
Behavioral Evaluation Report	10/16/012
Request for Reconsideration	10/30/2012
Individual Psychotherapy Notes	11/08/2012-11/13/2012
Work Capacity Evaluation	10/16/2012-7/07/2011
Letter of Medical Necessity	12/19/2012

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient is a male who worked as a heavy laborer. He is 5'2" and weighs 170 pounds. He reported back pain. There is no description of the injury. There are no objective findings of structural changes provided. The notes report that he had an orthopedic peer review which indicated he did have back pain prior to this incident. He has had therapy. The therapy notes were not provided. He did have psychotherapy and these notes indicate he was shown deep breathing and relaxation. He was prescribed Elavil for depression. His diagnosis is lumbar strain.

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

Per ODG references the requested 80 hours of Chronic Pain Management Program are not medically necessary.

Lumbar strain is a condition which normally resolves with or without treatment. The recommended treatment per the ODG is return to work. The strongest medical evidence regarding potential therapies for low back pain indicates that having the patient return to normal activities has the best long term outcome. (ODG Low back pain, 2010, p. 687) However, modified duty may be necessary. And in this case, the claimant worked as a heavy laborer. He may be unable to return to this type of work. He is not a candidate for a chronic pain program as all other methods of treating his lumbar strain have not been exhausted. There is no documentation of a daily exercise program, weight loss, back brace or indication of what current functional activities are. An adequate multidisciplinary evaluation has not been made. Imaging studies are not included. Chronic pain programs are recommended where there is access to programs with proven successful outcomes, such as decreased pain, improved function and return to work. There is no 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 is no documentation of the patient showing evidence of motivation to improve and return to work and meet the selection criteria. The predictors of failure in a CPP are poor work adjustment and satisfaction, a negative outlook about future employments, high levels of pretreatment depression, pain and disability, increased duration of pre-referral disability time, higher levels of opioid use and elevated pre-treatment levels of pain.



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

**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 KNOWLEDGE BASE
- 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