



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

Notice of Independent Review Decision

DATE OF REVIEW: 8/27/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 10 Sessions- 80 units.
5 x week x 2 weeks.

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

M.D. Board Certified in Physical Medicine and Rehabilitation.

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
Notice of Case Assignment	8/07/2013
Utilization Review Reconsiderations	6/25/2013-8/02/2013
IRO Report	2/26/2013
Pre-Authorization request	6/20/2013-7/26/2013
Clinical Interview	5/23/2013
Functional Capacity Evaluation Report	6/19/2013

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is female who reported neck pain. Her diagnosis is right shoulder strain and neck strain. She has had physical therapy for the injury. She is not taking any medications for management of her pain. She reports her pain as an 8 out of 10.



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There was an FCE showing her to be functioning at a sedentary level. She was seen for an IMR and no impairment was assigned for cervical spine. The shoulder was assigned 8% iR secondary to loss of range. MRI cervical spine shows no significant and subacromial bursitis. Her provider is requesting a chronic pain program (CPP).

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

Per ODG References, the requested "Chronic Pain Management Program x 10 Sessions-80 units 5 x week x 2 weeks" is not medically necessary. The request is not supported by the medical records. The patient reported pain in the neck and shoulder on 6/16/2011. She has had physical therapy, and does report pain; however, she takes no pain medications for her symptoms. There are no physical therapy notes provided for review to determine prior treatment. A home exercise program was not provided for review. There is no job description. She does not meet ODG for a CPP.

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