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## Notice of Independent Review Decision

**DATE OF REVIEW:** 8/5/2014

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of referral to Pain Management Specialist for Consultation related to symptoms of Lumbar Spine Injury as outpatient.

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

The reviewer is a Medical Doctor who is board certified in Chiropractic.

**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)

The reviewer disagrees with the previous adverse determination regarding the medical necessity of referral to Pain Management Specialist for Consultation related to symptoms of Lumbar Spine Injury as outpatient.

A copy of the ODG was not provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient injured his back on xx/xx/xx while on the job. The patient states he felt immediate lower back pain. He was initially referred to the employer's work comp doctor. He was given

a diagnosis of Lumbar strain 847.2 and Lumbar pain 724.3. He has undergone lumbar X-rays (Negative results for fractures or pathology) and prescription muscle relaxers and Ibuprofen. At the conclusion of his visit, he was referred to 6 therapy sessions over the next two weeks.

He was released to return to work without restrictions. After one week, however, he could not stay and perform his job duties due to pain in his lower back. He was then referred for pain management who ordered a lumbar MRI and steroid injections which were both denied by the insurance carrier. The patient has undergone a designated doctor exam in Feb 2014, at this time he was not at MMI. In Feb 2014, the patient was presented for treatment and continues to have a chief complaint of lower back pain.

He received a lumbar MRI on May 7, 2014 and it revealed disc space narrowing at L2-3 with a disc bulge and a borderline lateral recess stenosis at L4-5. In January, the evaluation concluded that the patient would be expected to reach MMI on or about May 27, 2014

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

Certification of requested program

Basis for Decision

- Referral to a pain management program is recommended for patients whose response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptoms severity.
- Patient exhibits excessive pain behaviour compared to that expected for diagnosis
- Risk factors are identified with available screening tools or there is previous medical history of delayed recovery
- The patient is not a surgical candidate
- Inadequate employer support or evidence of work organizational factors limiting return to work without interventions
- Evidence of psychosocial barriers that make return to work unlikely
- Loss of employment or evidence of partial disability involving ability to perform only 'part time' work or work with 'light duty' restrictions for greater than 4 months.

Therefore, the above listed patient has met these above guidelines.

References

- ODG – Official Disability Guidelines and Treatment Guidelines – Pain Chapter

**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 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)