



**Notice of Independent Review Decision - WC**

**DATE OF REVIEW:**

03/26/14

**IRO CASE #:**

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

Chronic Pain Management Program x 10 Sessions

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

Board Certified in Physical Medicine & 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Chronic Pain Management Program x 10 Sessions – UPHELD

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The date of injury was documented as xx/xx/xx. Documented on the date of injury, the patient was involved in a motor vehicle accident.

A lumbar MRI obtained on 01/29/10 revealed findings consistent with a disc protrusion at the L4-L5 level with a subligamentous disc herniation towards the right side, which did touch the thecal sac. There was evidence for hypertrophic changes in the facet joints. The

report described findings consistent with moderate-to-marked, right-sided foraminal stenosis at the L4-L5 level and slight-to-moderate, left-sided foraminal stenosis at the L4-L5 level.

The patient was evaluated on 12/16/13. On this date, there was documentation of limited range of motion with flexion of the lumbar spine. There was documentation of normal strength in the lower extremities.

A Functional Capacity Evaluation was accomplished on 01/09/04. This study revealed that the patient was capable of light category work activities. A mental health evaluation/assessment was accomplished on 01/10/14. It was documented that the patient was several years removed from undergoing lumbar spine surgery. It was documented that the patient was working at a church.

The patient was evaluated on 01/10/14. On this date, there were symptoms of low back pain with symptoms of numbness in the left lower extremity.

A mental health evaluation follow-up assessment occurred on 01/31/14. On this date, it was indicated that the claimant did not appear to be a good candidate for consideration of placement of a spinal cord stimulator.

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

Based upon the medical documentation currently available for review, a comprehensive pain management would not be supported as a medical necessity per the criteria set forth the Official Disability Guidelines. The records available for review would appear to indicate that the patient is presently a participant in work activities. Additionally, the length of time that the patient is removed from the onset of symptoms would be considered a negative predictor with regard to deriving any positive benefit from treatment in the form of a comprehensive pain management program. As a result, per the criteria set forth by the Official Disability Guidelines, the medical necessity for an extensive program in the form of a comprehensive pain management program is not established for the described medical situation.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**