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Notice of Independent Review Decision

DATE OF REVIEW: 3/26/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 80 hours/ Units. Outpatient.

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

D.O. Board Certified in Anesthesiology 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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who sustained a work related injury on xx/xx/xx when he fell from a 24 foot ladder. Patient sustained a closed head injury with associated head lacerations and injury to his neck and back. Patient had an MRI on 11/05/2013 that showed minor bulging at C3-C5 and L5-S1. Designated doctor gave him an IR % of 5 on 7/17/2014. Another MRI on 11/10/2014 showed 2 mm posterior central disc C4-C5, lumbar MRI showed grade 1 spondylosis at L5-S1 from bilateral spondylolisthesis of L5 and acute full thickness annular tear in the posterior fibers of the disc at L4-L5 and L5-S1. Patient had 19 sessions of physical therapy, 20 sessions of work hardening, and 4 sessions of individual psychotherapy. Functional capacity evaluation on 11/25/2014 showed sedentary PDL, psychological assessment on 1/12/2015 showed a BD 1-2 score of 18, and BAI score of 27. Presently patient is on Naproxen 500 mg bid and Tramadol 50 mg tid as needed. Patient continues to complain of a lot of pain and sleep deficit and functional deficit. On physical exam patient was reported to have neck pain with paresthesia left arm, low back pain with numbness in the left leg, and complaints of depression and anxiety.

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

Per ODG references, the requested services "Chronic Pain Management Program 80 hours/ Units. Outpatient" is not medically necessary. Patient has not exhausted all possible treatments that could possibly improve both his pain symptoms and depression/anxiety symptoms. Patient continues to complain of a lot of pain, sleep deficit and functional deficit. No documentation indicates the patient has consulted with either a pain physician or a



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surgeon to seek options for his pain relief.

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

- 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