

Independent Resolutions Inc.
An Independent Review Organization

Phone Number:
(682) 238-4977

835 E Lamar Blvd. 394
Arlington, TX 76011

Fax Number:
(817) 385-9610

Email: independentresolutions@irosolutions.com

Notice of Independent Review Decision

Case Number

Date of Notice: 02/17/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology And Pain Management

Description of the service or services in dispute:

10 sessions of chronic pain program

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)

The patient is a female who reported an injury XX/XX/XX. The mechanism of injury was lifting multiple heavy buckets of XX. The official MRI of the lumbar spine dated XX/XX/XX reported slight disc bulges at the L4-5 and L5-S1 levels with no canal or foraminal narrowing. The patient had attended at last 15 sessions of physical therapy from XX/XXXX through XX/XX/XX. The Functional Capacity Evaluation dated XX/XX/XX reported the patient to be at a sedentary physical demand level. The patient's occupation as a chef is noted to require a medium physical demand level. The behavioral evaluation dated XX/XX/XX indicated the patient reported pain in the lower back and hip on the right side. The patient reported that the pain radiated down to her right leg. The patient described the pain as constant, intermittent, stabbing, burning, sharp, throbbing, shooting, aching, numbness, and pins and needles. The patient reported weakness and having difficulty performing basic activities in her life. The patient's behavior evaluation and psychologic testing revealed a BDI-2 score of 20 indicating moderate depression, a BAI score of 20 indicating moderate anxiety, and FABQ-W score of 39/42 and FABQ-PA of 21/24. The most recent clinical note dated XX/XX/XX noted the patient complained of low back pain. The patient reported no significant changes since the last visit. The request has previously been denied due to the documentation provided shows that the patient has been previously recommended for injections and has also been recommended for individual psychotherapy and work conditioning. There were also recommendations for further physical therapy per the notes provided. In addition, the documentation only indicates that the patient has been using Flector patches for pain. There is no indication that she had tried prescription grade oral medication to relieve her pain and symptoms.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The Official Disability Guidelines state if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be limited to assessment whether surgery may be avoided; however, there was no indication or evidence to support the goal of treatment is to prevent or avoid controversial or optional

surgery. The Official Disability Guidelines also state previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. However, the documentation submitted for review indicated that the patient had been previously recommended for injections and has also been recommended for individual psychotherapy and work conditioning. Additional physical therapy was also recommended on previous therapy notes. In addition, the documentation indicated that the patient was using Flector patches for pain. There was no indication that the patient had tried prescription oral medications to relieve her pain and symptoms. Therefore, it cannot be supported that the patient had failed all lower levels of care or that there is a lack of further treatment options that would address the patient's condition. Therefore, the request would not be supported and the previous denial is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)