

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: 12/4/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of chronic pain management

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

A Chiropractor with 11 years of treating patients in the Texas Workers' Compensation system as a level II approved treating doctor

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

Notes from LPC dated 10/22/07 and 11/7/07, notes from DO dated 10/16/07, notes from PT dated 10/15/07, notes from Ph. D. dated 3/21/07, and cervical and left and right shoulder MRI dated 3/9/07, Letter from Health 11/14/07, Environmental Intervention 10/25/07, Denial Letters 10/29/07 and 11/14/07, Interdisciplinary Pain Treatment Components (no date), CPMP Design (no date), CPMP Day Treatment Plan (no date), CPMP Goals (no date), ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while working as a . The patient reported a repetitive motion injury to her neck, and both shoulders and arms.

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

The 20 sessions of chronic pain management are not reasonable or necessary according to the below referenced criteria. The MRI revealed an erosion of the right humeral head and a 3-4 mm osteophyte in the cervical spine. Both of these findings take time to develop and are a result of the normal aging process and cannot be linked to the patient's injury. The tendinous inflammation noted would be a result of the injury, however, according the Official Disability Guidelines, this would not be reasonable or necessary based on the diagnosis. Therefore, the 20 sessions of chronic pain management are not reasonable or necessary.

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)**