

True Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 12/12/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5 X 2.

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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

No ODG Guidelines
Denial Letters 10/12/07 and 11/14/07
CT: Lumbar Spine 10/28/06
Healthcare Letter 10/9/07, Diagnostic Interview Treatment Plan 10/2/07, Appeal Letter 11/5/07
Lumbar Discogram Unreadable Date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while on the job on xx/xx/xx. Since that time, the patient has undergone approximately 6-8 sessions of physical therapy and has also received “two injections” shortly after the injury. These interventional procedures were not helpful. The types of interventional procedures that were performed are not indicated in the records. The patient has also undergone a discogram which was positive for concordant pain at low pressures at L4-5 and L5-S1. There is no mention of the patient being evaluated by a surgeon to see if surgery is an option. The patient is also noted to have signs of depression and anxiety.

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

Per the Official Disability Guidelines, a chronic pain management program is considered medically necessary when “previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.” As stated above, the patient has undergone “two injections” since the injury. Again, the Reviewer is not exactly sure what types of interventional procedures have been performed. Therefore, the Reviewer’s medical assessment is that there may be other options available for this patient before being involved in a chronic pain program. In addition, the Official Disability Guidelines go on to state that the patient is also considered a candidate for a chronic pain program if “the patient is not a candidate where surgery or other treatments would clearly be warranted.” This patient may not be a candidate for surgery, but the Reviewer has not seen an evaluation by a surgeon stating that the patient is not a candidate. With a positive discogram at L4-5 and L5-S1, the Reviewer’s medical assessment is that are other options. Therefore, this criterion of the Official Disability Guidelines has not been met

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)