

# True Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 214-276-1904

## IRO REVIEWER REPORT TEMPLATE -WC

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### **DATE OF REVIEW:**

12/21/07

### **IRO CASE #:**

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

Pain management program daily for two weeks (five days a week)

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

M.D., neurologist, fellowship trained in Pain Management, Board certified in Neurology and Pain Medicine

### **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

Notification of Denial for requested service dated 11/21/07 as well as 12/06/07

Notes from Imaging dated 08/24/07 and 09/07/07

Various office note visits from Dr. (Chiropractic Clinic), last one being dated 11/01/07

Review of medical records by Dr. dated 10/11/07

Request for Medical Dispute Resolution by Rehabilitation Institute dated 12/14/07 as well as Intake Evaluation by this same company

Report of EMG testing

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant sustained a work-related injury reportedly while “turning a box” with subsequent pain in the right shoulder area. Initially this was treated with ibuprofen, Zanaflex, and Ultram. Imaging reports were subsequently done with cervical spine x-rays showing some straightening of the normal curvature, mild diminishment of disc spaces at C5/C6 and C6/C7, and mild bone spurring with no instability noted on flexion

and extension views. Thoracic spine x-rays showed a mild scoliosis. Right shoulder x-rays were reportedly unremarkable. Eventually, right shoulder MRI scan was also done that reportedly showed a prominent acromioclavicular joint with soft tissue densities reportedly noted of uncertain origin. MRI scan of the cervical spine again showed reduction in the normal curvature suggestive of muscle spasm, mild disc protrusion at C3/C4 and C4/C5 without obvious spinal cord compression or neural foraminal narrowing. This claimant subsequently underwent a steroid injection into the right subacromial region on 08/24/07 but without any significant symptomatic relief. An EMG/NCV study was then performed, which did not show any evidence of cervical radiculopathy or any other peripheral neuropathic process in the right upper extremity. Further evaluation was recommended by Dr. who had performed the right shoulder injection including possible further evaluation with a right shoulder arthrogram MRI scan and/or orthopedic surgeon consultation. The Reviewer does not see any evidence that either of these has taken place, nor does the Reviewer see any consultations by pain management specialists or psychiatric specialists outside of the intake evaluation at Rehabilitation Institute, a multidisciplinary chronic pain management program.

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

It appears to this reviewer that the request for a multidisciplinary chronic pain management program is premature at this point. The claimant was injured earlier this year and has undergone treatment limited currently to chiropractic intervention, some physical therapy and medication trials, and one injection into the right shoulder/acromioclavicular joint presumably. In general, the Reviewer does not feel that this claimant has undergone the usual preliminary and even secondary steps that are usually undertaken prior to referral to this type of program.

**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)