

# True Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW: 01/25/09**

**IRO CASE #:**

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

Chronic pain management program 5x2

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

Clinical psychologist; Member American Academy of 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 10/31/08 and 11/25/08

Records from 4/16/07 thru 11/18/08

FCE 5/15/07 and 6/28/06

Letter from 1/12/09

8/10/06 thru 12/2/08

7/13/06 thru 11/27/06

MRI 7/20/06

10/06

12/19/06

5/29/06 and 5/30/06

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year-old female who sustained a compensable, work-related injury to her low back on xx/xx/xx. Patient was performing her usual job duties as a for , when records indicate she began experiencing low back pain as she was in the process of lifting buckets of roofing cement onto a pallet. This occurred on a Friday, and the following Monday, patient presented to the emergency room for continued pain and spasming. She was prescribed Naprosyn, Flexeril, and Lortab and given work restrictions. She continued to work for about 2 months on light duty, but was unable to sustain this, and was taken off work by her treating physician. Since this time, patient has not returned to work.

Over the course of her treatment, patient has received x-rays, lumbar MRI's, physical therapy (2006), pain management x 2 days (2007), lumbar discogram with annular tear revealed on post-discogram CT (2007), lumbar ESI's (2007), lumbar fusion surgery (2007), post-surgical physical therapy (2007), SCS implantation (2008), negative EMG (2008), psychological evaluation (2008) , and medications management. Patient is currently prescribed Hydrocodone, Amerex, Lyrica, and Ambien. On January 28, 2008, patient was placed and MMI and given a 5% impairment rating. FCE indicated patient could work at a light duty level.

Patient was referred by her treating doctor to determine appropriateness for a chronic pain management program. Psychological evaluation completed October 20, 2008 states that the patient's spinal cord stimulator "died" on September, 2008, and patient is currently reporting average daily pain at a 6-7/10 level, with escalations to 9/10. Additionally, she is reporting 3 hours of sleep per night due to pain, as well as numerous other emotional, behavioral, social, and physical interferences related to the pain. Results of the assessment "suggest that the patient is experiencing psychological distress manifested by anxiety (BAI = 7), depression (BDI = 24), sleep disturbance, and preoccupation with functional deficits and chronic debilitating pain." Results of testing also showed distorted beliefs regarding the danger of physical activity and low expectations for recovery. Plan is to use cognitive-behavioral, supportive psychotherapy, biofeedback, stress management, coping skills training, etc. to remediate her depression and increase functionality. Request is for 10 days of a chronic pain management program.

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

Letter from the insurance company's attorney dated 1/12/09 states that "on September 17, 2008, patient underwent replacement of the IPG battery. On October 8, 2008, the Claimant followed up with Dr. ...and stated that she was doing well with the spinal cord stimulator."

ODG states that the candidate must be an "appropriately identified" patient who is able to benefit from a functional rehab program. The program should include medical, physical, and behavioral components. The current request only appears to suggest to use psychotherapeutic interventions during the recommended chronic pain management program, which is not appropriate. There are also significant number of Waddell's signs that patient produced at IR exam which need to be examined. Additionally, there is no explanation regarding whether or not the SCS is working and if so, why it is not providing pain relief. If these issues can be resolved, patient may be appropriate to follow a stepped-care approach to treatment in the future, as suggested by ODG.

Given the above, request cannot be established as medically reasonable and 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)**