

SENT VIA EMAIL OR FAX ON
Oct/13/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured on xx/xx/xx when she fell . She had low back pain, knee pain and left shoulder pain. She subsequently was found to have a left rotator cuff tear and underwent surgery in November 2008. She has medial and lateral meniscal tears with retropatella pain, and chronic low back pain. She was found to be at MMI with adhesive capsulitis. Dr. performed an assessment on her and found minimal depression and minimal anxiety. She had a lot of fear avoidance issues reflected as severe perceived disability on her Oswestry testing. Dr. advises a 10-day pain program. The goals are to reduce her pain, depression and anxiety. She had prior work hardening, but there is no report. There are comments about a 006 FCE, but the Reviewer did not see any more recent. Although the Reviewer is not sure there will be a favorable outcome, there are no other alternative treatments currently to offer her. Therefore, a 10-day trial is justified.

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

The injury occurred xx years ago, but surgery was last year. She is not working and there is no discussion of any plans for her to return to work. This is a negative predictor. The goals provided did not include any plans to return to work. However, this may not be the sole criteria in someone her age. She meets the diagnostic criteria for a chronic pain syndrome. The Reviewer did not see a functional assessment. She has more of fear avoidance issues. These should have been previously addressed in the psychological assessment, but the Reviewer could not determine that in the records. There is no history of any excess medication use. She has sought different health care providers for treatment.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE A DESCRIPTION)