

SENT VIA EMAIL OR FAX ON
Oct/27/2009

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5 X 2

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

OD Guidelines
Denial Letters 7/27/09 and 8/17/09
6/18/09 thru 9/28/09
Dr. 3/8/09
MRI 5/6/08
Dr. 10/23/08
Dr. 8/5/09
Dr. 6/23/09
Carrier 439 pages from 4/10/08 thru 10/8/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured on xx/xx/xx while on the job. The symptoms were in the low back and right hip. The MRI showed multiple level lumbar disc bulges and facet deterioration. There

was moderate right foraminal narrowing. There was no evidence of nerve root compromise. The electrodiagnostic study reported a prolongation of the right H reflex consistent with an S1 radiculopathy. There was evidence of bilateral tibial neuropathy negating the H reflex interpretation. He had a lumbar ultrasound reportedly showing facet effusions and deterioration. This test, to my knowledge, is not accepted as being valid by the AIUM. He failed to improve with therapy. Two FCEs showed him to be at a sedentary light PDL, but his job required a medium level PDL. He reportedly attempted to return to work, but this was denied by his employer. Dr. 's 7/8/09 described him as wanting to return to work and be more active. He is not taking opiates.

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

Dr. and Dr. provided answers to the two prior denials. The responses were in detail and challenged the other reviewers' opinions. As noted above, there is no documented evidence of a radiculopathy, but does describe radicular symptoms and the S1 dermatomal sensory decrease. There is no other treatment program available. The patient wants to work and get better. There appears, per Dr. and Dr. , a circular reasoning regarding psychological assessment, denial and need for treatment. From their description, this man appears to meet the requirements for the initial 10-day session of a chronic pain program.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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