

SENT VIA EMAIL OR FAX ON
Oct/28/2009

Pure Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 5 X 2

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

Physician's 11/20/08, 5/21/09, 7/22/09, 8/28/09

10/7/09

Records from Insurance Carrier 328 pages from 4/19/07 thru 9/8/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured on xx/xx/xx performing her regular job duties. She was either lifting or stacking boxes when she felt a sharp pain in her lower back. She continued to work for the next three weeks, with pain worsening, before she reported the incident to her supervisor. Date of injury is xx/xx/xx. Patient established care with Dr. . She has been returned to work with restrictions since the injury, but patient is not currently working. There is no vocational history in the initial evaluation submitted for review, and therefore no detail of if patient ever attempted to return to work, for how long, how she fared, etc.

Since the injury, patient has been given diagnostics and interventions to include: lumbar MRI's, EMG's, FCE's, ESI's, individual therapy, physical therapy, and medication

management. Current medications include Soma, Hydrocodone, Ibuprofen, HTCZ, citalopram, and a transdermal topical gel formulation prescribed by her treating doctor. Initial MRI in 2007 was positive for 1-4 mm lumbar herniation. Patient was diagnosed with lumbar sprain, lumbar radiculopathy, and herniated disk. FCE completed February 2008 placed claimant at the light-medium PDL with her job being considered a medium PDL. She was recommended to continue her home exercises and was placed on restricted return-to-work. Current FCE continues to place her at or close to this range, but report states that her RTW PDL is now Heavy. Patient was seen May 2009 by Dr. orthopedist, to rule out surgery. He requested updated MRI, "in order to know the current anatomical status and the source of persistent pain." After reviewing the new MRI, surgery was ruled out. Report states that "patient does not have any apparent disk herniation, bulges, or foraminal neural compression on repeat MRI performed on 5/20/09". Currently, patient continues to report pain at an average 5/10 and she has been referred by her treating doctor for a chronic pain management program which is the subject of this review.

Current team treatment plan states that "at the time of her initial evaluation, her diagnoses were lumbar sprain, lumbar radiculopathy, and herniated disk." Surgical screening report states patient has difficulty with standing more than 10 minutes, sitting or driving too long. Initial eval states patient has sleep disturbance with average 2 hours sleep per night, medication dependency, and pain related symptoms of nervousness and headaches. Psychometric testing shows severe depression and moderate anxiety, moderate disability complaints (ODI of 44), perception of pain as being 5-6/10 VAS, significant fear-avoidance beliefs, and reduced physical capabilities. Patient report shows no Axis V diagnoses. The current request is for initial trial of 10 days of a chronic pain management program. Goals for the program include: weaning of medications by 50%, reduce anxious/depressed symptomatology by 80%, improve overall mobility and functioning, and reduce pain score from 5 to 2. Vocational goal is to return to the workforce.

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

Goals for the program are vague and generalized, and not really individualized for this particular patient. Initial behavioral report does not include a cohesive history, does not include a mental status exam or diagnoses, and team treatment report has only one signature on it. ODG states that an adequate and thorough evaluation has to have been made. Baseline functional testing was done, but there is no cohesive plan flowing from this testing. Additionally, there is no specific titration schedule with regard to her narcotic medications, and no specific vocational plan or information about whether previous job is even still an option. An FCE was administered, but no PT or other such eval in order to make specific physical conditioning recommendations for this patient. It is unclear how many IPT sessions patient was previously approved for and whether or not she was compliant in attending these. Also, there is no explanation for why she failed PT and IT, how the current program would be different, why her pain scores have decrease from average 8/10 to 5/10 over the past three months, and why she has not been able to go back to work as a cashier. Given the above mentioned contraindications, the current request cannot be considered reasonable or medically necessary.

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)