

SENT VIA EMAIL OR FAX ON  
Apr/16/2010

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/16/2010

**IRO CASE #:**

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

Chronic Pain Management 80 hours 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  
Denial Letters 2/11/10 and 3/4/10  
xxxxx 10/15/08 thru 2/8/10  
Pain & Injury Relief 1/6/10 thru 3/24/10  
Dr. 6/8/09 and 7/7/09  
MRI 10/23/08  
xxxxxx 6/24/09  
Lumbar Spine 10/16/08

**PATIENT CLINICAL HISTORY SUMMARY**

Mental health re-eval dated 12/29/09 reports that patient was injured on xx/xx/xx while performing his regular job duties. On the above-mentioned date, he was unloading 18-wheeler tires and twisted to set a tire onto a stack. Patient reports experiencing pain and numbness following this activity and began seeking treatment with Dr. and Dr.. He remains in an off-work status.

Records indicate that over the course of his treatment, patient has received x-rays, lumbar MRI's, one injection, physical therapy (5 visits which patient stated he did not benefit from and quit), FCE x 2 done by Occupational Assessment Services (both place patient in the Light PDL), EMG/NCV (negative), and medications management. Diagnoses listed on the current report are: lumbar disk herniation, lumbar radiculitis, myalgia, and chronic pain syndrome. Diagnoses by Dr., who evaluated the patient on 1/6/10 are: lumbar nerve root irritation, lumbar discogenic pain, lower back pain, lower extremity paresthesia, and groin paresthesia. Dr. prescribed Norco, Zanaflex, and Mobic. Office note from Dr. (8/6/09) show prescriptions for Soma and Vicoden and diagnosis of lumbar radiculopathy. MRI

date 10/23/08 by xxxxx shows impression of "multilevel spondylosis without evidence of high grade spinal stenosis or high grade neural foraminal narrowing identified".

Current request is for additional 10 days of a CPMP. Records available for review of the 80 hours already completed are a one hour vocational assessment note (incomplete), a PT summary note (patient has been unable to yet reach his target heart rate), and an outcomes grid that show an increase in depression (BDI from 15 to 20), BAI reduced three points, no change in FABQ, ODI, pain reports, or BPI. Also, no change from FCE in PDL level of Light.

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

ODG states that "an adequate and thorough evaluation" has to have occurred, which should include baseline functional testing so follow-up with the same test can note improvement or lack thereof." There are no specific, individualized and objective treatment goals in the behavioral report for this patient and no mental status exam. It is difficult to tell who is the patient's treating doctor, and there is no MD assessment of the patient for this program.

Most of the paperwork is in a standardized form, and offers discrepant information (vocational goal of return to work, versus this is not a goal of the program). Additionally one goal was to decrease reliance on medication, but there is no assessment, treatment plan, or diagnosis to elucidate this further, and it is somewhat unclear who is prescribing the patient's meds and exactly what they are. There is no urine drug screen, weaning protocol, referral to addiction specialist (if appropriate), etc.

TDI-DWC has adopted the ODG treatment guidelines as the standard for non-network workers' compensation claims. Based on ODG criteria and the records submitted for review, the current request is deemed not medically reasonable and necessary at this time.

**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)