

SENT VIA EMAIL OR FAX ON
Feb/10/2011

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of chronic pain management

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

Board Certified Orthopedic Surgeon

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

Peer Review 12/13/XX, 01/06/XX

Dr. letter 12/01/XX, 12/02/XX, 12/16/XX, 01/19/XX

Functional Capacity Evaluation 12/01/XX

Mental Health Evaluation 12/02/XX

Physical Therapy record 12/02/XX

Letter from claimant 01/20/XX

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a reported injury date of XX/XX/XX. The records indicated that the claimant was standing on a ladder while cleaning when the ladder fell and she landed on her back. Neck and back pain was reported. A physician record dated 12/01/XX noted the claimant with neck pain with radiation to both hands and low back pain with radiation to both feet with associated intermittent pelvic pain. Weakness, numbness and tingling in all four extremities was also reported. Chronic bilateral lumbar radicular pain, chronic bilateral

cervical radicular pain and chronic pain syndrome was diagnosed. A past history included lumbar injections, no lumbar surgery, diagnostic studies, chiropractic adjustments and ten days of a rehabilitation program. Goals for treatment were outlined and the claimant was referred for a functional capacity evaluation and a physical therapy evaluation.

A functional capacity evaluation performed on 12/01/XX. It recommended that the claimant was a candidate for a pain management program due to observed inhibition, fear avoidance, physical function limited by pain and length of injury. A mental health evaluation performed on 12/02/XX revealed the claimant with sufficient critical issues to meet the criteria to benefit from an interdisciplinary rehabilitation program. A therapy evaluation dated 12/02/XX outlined treatment goals and a treatment plan for pain management functional restoration approach.

A follow up physician record dated 12/02/XX noted the claimant impressed with the pain management program and noted that she made very little progress with her attendance at a previous program for ten sessions. The claimant now was reportedly desperate to return to work and seemed genuinely motivated to attend an additional ten functional restoration visits. Medication adjustments were made and the claimant was referred to the PRIDE program for completion of the last ten visits of a functional restoration program.

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

Ten sessions of chronic pain management would not be considered medically necessary or appropriate based upon review of the records provided in this case.

If one reviews the Official Disability Guidelines, this claimant meets many of them. However, the guidelines do state that the patient should exhibit motivation to change, be willing to decrease opiate dependence and forgo secondary gains, including disability payments to affect this change, and that treatment should not go for longer than two weeks without evidence of compliance and significant demonstrated efficacy, as documented by subjective and objective gains.

There is documentation that this claimant has undergone a previous pain program for 10 sessions at clinic where she made very little progress. Following this, she went back on hydrocodone, Cymbalta, and started Lyrica. She did not get back to working in any capacity.

Therefore, based upon the Official Disability Guidelines, an additional ten sessions of chronic pain management would not be considered medically necessary or appropriate in this case.

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)