

SENT VIA EMAIL OR FAX ON  
Jul/14/2011

## True Resolutions Inc.

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

**DATE OF REVIEW:**  
Jul/14/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Chronic pain management program for left shoulder pain 5 times per week for 2 weeks; out-patient

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified PMR and 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

1. Cover sheet and working documents
2. Utilization review determination dated 05/24/11, 06/14/11
3. Request for services dated 05/04/11
4. Functional capacity evaluation dated 04/25/11
5. Request for reconsideration dated 06/08/11
6. Request for medical dispute resolution dated 06/28/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. Functional capacity evaluation dated 04/25/11 indicates that required PDL is heavy and current PDL is sedentary to light. Psychological evaluation dated 05/04/11 indicates that medication includes Celebrex. The patient has reportedly undergone a course of individual psychotherapy. BDI is 34 and BAI is 17. Diagnoses are adjustment disorder with mixed anxiety and depressed mood and pain

disorder with both psychological factors and a general medical condition.

Initial request for chronic pain management program was non-certified on 05/24/11 noting that insufficient documentation to support the request. There is no pain generating structure clearly identified. The patient is on minimal medication. No specific functional deficits are noted. There is no documentation of injection therapy. The denial was upheld on appeal dated 06/14/11 noting that there is no current physical examination provided.

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

Based on the clinical information provided, the request for chronic pain management program for left shoulder pain 5 times per week for 2 weeks; outpatient is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient sustained injuries approximately xx years ago. The Official Disability Guidelines do not recommend chronic pain management programs for patients whose date of injury is greater than 24 months old as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. The patient is currently only taking Celebrex. Given the current clinical data, the requested chronic pain management program is not indicated as 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)