

SENT VIA EMAIL OR FAX ON
Jun/23/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program X 40 hours

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

PATIENT CLINICAL HISTORY SUMMARY

The patient is a XX year old male whose date of injury is XX/XX/XXXX. On this date the patient was attaching and felt pain in the left side of his back. Treatment to date is noted to include diagnostic testing, massage, TENS unit and physical therapy. Work capacity evaluation dated 04/08/11 indicates that required PDL is heavy and current PDL is light-medium. Behavioral evaluation report dated 04/08/11 indicates that BDI is 20 and BAI is 14. The patient returned to light duty work after one week of physical therapy until 03/02/11 when the patient's employer informed him that light duty work was no longer available. Current medication includes Zipsor. Diagnoses are adjustment reaction and pain disorder associated with both psychological factors and a general medical condition. Initial request for chronic pain management program was non-certified on 05/06/11 noting that the records submitted for review did not contain a recent clinical assessment from a treating physician containing comprehensive subjective and objective findings. Specific short and long term physical therapy goals within the program were not provided. The denial was upheld on appeal

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 x 40 hours 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 indication that the patient has undergone any recent active treatment. There is no indication that the patient has undergone a course of individual psychotherapy. 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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES