

SENT VIA EMAIL OR FAX ON
Apr/20/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPMP 5 X 2

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

AADEP Certified
Whole Person Certified
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy
Chiropractor

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
12/28/10 thru 4/5/11
Clinic 2/24/11
FCE 6/30/09
Foot and Ankle Care 3/8/10 and 2/8/10
CT Lower Extremity 2/4/10
MR Ankle and Knee 1/5/10
SRS 3/2/11 and 3/17/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee was involved in an occupational injury on xx/xx/xx when she apparently slipped and fell down a flight of stairs landing on her hands and knees. She is currently diagnosed with CTS, meniscal tear and a fracture of the ankle. She had undergone PT, TENS unit, medication, x-rays, MRI, pain injections, surgery, post-op PT, FCE, psychological

evaluation, and individual psych sessions x6. Psychological evaluation / follow-up dated 2/24/2011 indicated that her psychological symptoms appear to be dysomnia, restlessness, irritability, unsteadiness, libido decrease, fatigue, motivation decreased, not able to relax, difficulties adjusting to the injury, frustration, fear of re-injury, and boredom. Current medications are Hydrocodone, Ultram, and IBP. The injured employee rates her pain level a 9 out 10 VAS, Beck Depression 7, BAI 8, SOAPP-R 7, FABQ physical activity 6 and Work scale 24. Treating physician indicates all lower level care has been completed; therefore, a trial of 10 sessions of chronic pain management is being requested. A treat plan, job simulation, and FCE are included in medical documentation

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

The injured employee currently does meet the required guidelines for a trial of 10 sessions of chronic pain management. Medical records provided support the request for 10 sessions of chronic pain management. The injured employee has exhausted lower level care, including surgery and pain injections. The injured employee has chronic pain syndrome beyond 3 months (#1), loss of ability to function (#2) as indicated by FCE, treatment of chronic pain symptoms has been unsuccessful to date(#3), the injured employee had surgery and is not a candidate for further surgical procedures (#4), adequate and thorough multidisciplinary evaluation has been made (#5) with psychological testing, FCE, patient exhibits motivation to change (#6) the injured employee takes medication as indicated in report with a SOAPP-R of 7 (low risk for abuse), negative predictors of success above have been addressed (#7) in request / treatment plan and job simulation, (#8) the program may be used for both short-term and long-term disabled patients, treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy (#9) as indicated by 10 sessions being requested, (#10) total treatment duration should generally not exceed 20 full-day sessions as indicated by 10 sessions be requested, and finally at the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (#10).

ODG-Guidelines for Chronic pain programs (functional restoration programs)

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
- (2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
- (3) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;
- (4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits

may be implemented to assess whether surgery may be avoided;

(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note [functional and psychological improvement](#);

(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;

(7) Negative predictors of success above have been addressed;

(8) These programs may be used for both short-term and long-term disabled patients.

See above for more information under *Timing of use*;

(9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program;

(10) Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;

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