

SENT VIA EMAIL OR FAX ON
May/16/2011

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management times 10 days

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 04/08/11, 04/20/11
3. Request for services dated 03/28/11
4. Functional capacity evaluation dated 03/29/11
5. Request for reconsideration dated 04/13/11
6. Request for medical dispute resolution dated 04/29/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was driving when his truck caught on fire. He noticed intense pain and has not been able to work since then. Treatment to date includes posterior decompression and fusion of L4 through S1, medication management, medication management and individual psychotherapy. Current medications include Ordus, Skelaxin and Neurontin. BDI is 32 and BAI is 28. Functional capacity evaluation dated 03/29/11 indicates that the patient's maximum work PDL for lifting is light and present functional abilities are in the sedentary PDL.

Initial request for chronic pain management program was non-certified on 04/08/11 noting that the submitted records report that the patient has undergone many 1st and 2nd lines of treatment to include medication management for both pain and depression, rehab programs, surgical intervention and other treatment approaches that the claimant felt had adequately relieved pain. The denial was upheld on appeal dated 04/20/11 noting that the patient's date of injury is greater than xx years old and there is no reasonable expectation that the patient will benefit or improve from this program.

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 times 10 days is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained injuries over xx years ago and has not worked since that time. The Official Disability Guidelines do not recommend chronic pain management programs for patients whose date of injury is greater than 24 months old. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records indicate that the patient has undergone previous rehab programs; however, the nature and extent of these programs are not documented. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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)