

SENT VIA EMAIL OR FAX ON  
Oct/13/2011

## True Resolutions Inc.

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

**DATE OF REVIEW:**

Oct/11/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management Program X 10 days or 80 hours

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

PMR

**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

Cover sheet and working documents

Utilization review determination dated 08/29/11, 09/12/11, 08/01/11

Letter of appeal to IRO dated 09/28/11, 08/30/11

Letter of appeal dated 08/19/11

Progress note dated 05/10/11, 04/12/11

Letter of medical necessity dated 07/11/11

MRI lumbar spine dated 09/13/10

Patient assessment request for 10 day functional restoration program dated 07/14/11

Psychosocial evaluation dated 07/14/11

BHI2 report dated 07/14/11

PPE dated 07/14/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell due to a rubber strip at the edge of a step that was loose. The patient subsequently complained of low back pain radiating to the lateral aspect of the right leg to the big toe. PPE dated 07/14/11 indicates that surgery helped somewhat. Psychosocial evaluation dated 07/14/11 indicates that the patient rates her depression as 8/10. The patient was previously prescribed Zoloft, but she stopped taking it because she could not afford it. BDI is 27 and BAI is 25. Diagnoses are chronic pain disorder, depressive disorder and sleep disturbance.

Initial request for chronic pain management program was non-certified on 08/01/11 noting that lesser levels of care have not been exhausted, and there is documentation available for review which would appear to indicate that prescription medications are not provided for management of pain symptoms. The request was non-certified on 08/29/11 noting that the submitted psychosocial evaluation is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. There are no offered diagnostic impressions, inconsistent with appropriate evaluation of psychological complaints. There is no documentation that the patient's treating physician has ruled out all other appropriate care for the chronic pain problem. Appeal letter dated 08/30/11 indicates that the patient has undergone extensive lower level care including oral pain medications, surgical intervention, physical therapy and steroid injections. The denial was upheld on appeal dated 09/12/11 noting that the patient is currently working with restrictions, and it is unclear why such an extensive interdisciplinary treatment program would be needed for an individual where reportedly the patient is currently working with restrictions. There is no evidence provided to indicate that the treatment team has exhausted all appropriate treatments for this patient. Letter of appeal to IRO dated 09/28/11 is a duplicate of the letter dated 08/30/11.

**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 10 days or 80 hours is not recommended as medically necessary, and the 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 has been diagnosed with depressive disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy, and the patient is not currently taking antidepressant medication. 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**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**