

SENT VIA EMAIL OR FAX ON
Jan/25/2012

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 days of interdisciplinary pain rehabilitation program 8 hours per day 5 times a week

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

PM&R and Pain Medicine

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 12/20/11, 01/04/12

Letter dated 01/16/12, 12/22/11

Functional capacity evaluation dated 10/28/11

Office visit note dated 11/21/11

Request for services dated 12/14/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient reports that a jumped onto her back causing pain to her neck and back. Functional capacity evaluation dated 10/28/11 indicates that current PDL is sedentary light and required PDL is light. Current BDI is noted to be 19 and BAI is 12. Current medication is listed as Tylenol OTC. Diagnosis is listed as pain disorder associated with both psychological factors and a general medical condition, chronic.

Initial request for 10 days of interdisciplinary pain rehabilitation program was non-certified on

12/20/11 noting that the patient is a. This is a light PDL and there is no indication for work restriction. Her physical examination is consistent with cervical and lumbar strain with no radiculopathy. This condition has long ago resolved. She may return to work if she wishes. There is no indication for pain program rehab. The denial was upheld on appeal date 01/04/12 noting that there is no functional capacity evaluation available for review. The claimant has not undergone any type of psychological testing by physical examination findings and clinical data for review the claimant is using over the counter medications currently and has no clinical radiculopathy to the upper or lower extremities. Without documentation of specified functional or vocational deficits with analysis of current behavioral assessment and without need of detoxification of medication or significant improvement for job performance function, and as the claimant has returned to work with restriction, the request for a chronic pain management program is not medically supported.

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 10 days of interdisciplinary pain rehabilitation program 8 hours per day 5 times a week is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records therefore 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 clear rationale provided as to why remaining deficits cannot be addressed with a structured home exercise program to return the patient to a light physical demand level. The patient sustained a cervical and lumbar strain which should have resolved at this time. The patient is not currently taking any narcotic or psychotropic medications, and the patient's current medication is listed as OTC Tylenol.

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)**