

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 day trial Chronic pain management program-80 hours

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

Board Certified Physical Medicine and Rehabilitation 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Designated doctor's evaluation dated 04/27/12

Independent medical evaluation dated 08/14/12

Prior IRO dated 06/06/12

Initial behavioral medicine consult dated 03/21/12

History and physical dated 08/13/12

Assessment and evaluation for chronic pain management program dated 08/15/12

Physical performance evaluation dated 08/16/12

Psychological testing report dated 08/27/12

Request report for chronic pain management program dated 09/07/12

Reconsideration request dated 09/21/12

Prior reviews dated 09/12/12 and 09/20/12

Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient felt injury or tear to low back. To date the patient is status post work hardening. This was completed in 02/12. The patient's independent medical evaluation dated 08/14/12 revealed loss of range of motion of lumbar spine on flexion and extension. Minimal effort was noted and only demonstrated limitations in lumbar mobility during exam. The patient was observed being able to easily climb into a vehicle and demonstrated no observed difficulties. Further treatment was not recommended. The patient was recommended for individual

psychotherapy on 03/21/12 due to elevated BDI and FABQ scores. Physical performance evaluation completed on 08/15/12 placed the claimant at medium physical demand level and the claimant required a heavy physical demand level. A repeat psychological test evaluation dated 08/27/12 reported BDI score of 15 and BAI score of 5. FABQ score for work was 28, for physical activity was 18. The patient had a valid MMPI II result and BHI-II testing revealed high level of functional disability that is commonly seen in patients with severe peak pain in VAS scale. The patient was found to have high levels of anxious thoughts and feelings. The patient was recommended for chronic pain management program for 80 hours.

The request for initial chronic pain management 80 hours was denied by utilization review on 09/12/12 as the patient had recently performed work hardening program and chronic pain management program should not be considered stepping stones for less intensive programs.

The request was again denied by utilization review on 09/28/12 as there was insufficient evidence to support admission to comprehensive pain rehabilitation program. The patient did not undergo extensive psychological testing to support diagnosis of pain disorder.

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

The request for a trial of 80 hours of chronic pain management program would not be recommended as medically necessary based on clinical documentation submitted for review. The patient previously underwent work hardening program which failed to return patient to work. Current evidence based guidelines do not recommend repetition of similar rehabilitation programs and does not recommend the use of chronic pain management program for stepping stone for further treatment. The patient's psychological evaluation was limited and full psychiatric evaluation was not performed. Additionally, there does to be secondary gain factors as the most recent independent medical evaluation found the patient had symptom magnification with over reporting of pain and demonstration of significant restriction in lumbar spine later observed not to be present. As the clinical documentation provided for review does not meet guideline recommendations for the request, medical necessity is not established and prior 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)