

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Oct/27/2014

**IRO CASE #:**

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

Additional chronic pain management program 80 hours, 5 x wk x 2 wks

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

DO, Board Certified PM&R

**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.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. Progress summary dated 08/20/14 indicates that the patient began attending chronic pain management sessions on 08/11/14. The patient continues to be invested in the program. He is more aware of the thought processes that intensify his emotions such as agitation, irritability, hopelessness, frustration and anger. The patient reports that he has reduced his medications to an as needed basis. BDI decreased from 47 to 23 and BAI from 10 to 9. Functional capacity evaluation dated 09/04/14 indicates that the patient was recommended to continue chronic pain management program.

Initial request for additional chronic pain management program 80 hours was non-certified on 08/26/14 noting that evidence of his functional gains including improvement in PDL had not been reflected in the records reviewed. The denial was upheld on appeal dated 09/24/14 noting that the patient's job demands are characterized as medium to heavy on the 07/23/14 functional capacity evaluation. He was deemed to be at a sedentary-light demand level on 07/23/14. There is no similar scale to indicate what kind of progress this patient is making with his functional and physical capabilities. Without such measures it is impossible to determine whether or not he has made sufficient progress to qualify for an extension in the chronic pain management program.

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

The patient has completed 10 sessions of chronic pain management program to date. The Official Disability Guidelines note that treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. There are no significant measures of improvement documented to establish efficacy of treatment and support additional sessions in the program. The issues raised by the initial denials have not been adequately addressed to support a change in determination. As such, it is the opinion of the reviewer that the request for additional chronic pain management program 80 hours, 5 x wk x 2 wks is not recommended as medically necessary.

**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)