Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 2, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Chronic Pain Management, 5XweekX 2 weeks

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

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

XX Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
726.2	Chronic Pain Mgmt		Prosp	10					Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO

Respondent records- a total of 23 pages of records received to include but not limited to:

letter, 2.8.07, 3.5.07, 3.15.07; DWC 69; DDE report, 12.13.06; Pain and Recovery Clinic notes, 12.26.06-1.31.07; MH Evaluation, 12.29.06

Requestor records- a total of 15 pages of records received to include but not limited to:
Pain and Recovery Clinic notes, 1.3.07-3.19.07; MH Evaluation, 12.29.06

PATIENT CLINICAL HISTORY [SUMMARY]:

This gentleman was injured. He had two surgeries for rotator cuff injury. He continues to have pain and was seen by designated doctor, Dr. on December 13, 2006. Dr. indicated he did not believe the patient would reach MMI until at least February of 2007 and just initiated pain management program with Dr. and felt that that would be an appropriate treatment. Documented hypertrophic scarring. Recommended dermatology assessment. Carrier denied that program indicating that no significant functional improvement in the shoulder had occurred and only a two-point drop in pain reported on visual analog scale.

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

Pain management programs are not to treat functional assessment. They are to treat patient's coping ability and management style and to help diminish use of resources such as medications. This patient has shown diminished medication usage, has shown diminished self-pain reporting, and it would be appropriate and reasonable given the longevity of his injury and the permanency of his disability with rotator cuff tear and two surgeries to complete a pain program. This will be the only treatment available to him and on completion no additional treatment beyond use of oral medications provided by treating physician would be appropriate. The role of the IRO is not to "ODG Guidelines" but to apply clinical sense to cases similar to the types of cases we see in practice. Therefore, using my many years of experience and practice in physical medicine treating the patient with similar diagnosis and problems, I have made these recommendations.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN 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**
- **XX 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)**