

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of Chronic Pain Management Program.

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

M.D., Board Certified Internal Medicine
Member American College of Occupational and Environmental Medicine
12 years practicing Occupational 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)

Upon independent review the reviewer finds that the requested 10 sessions of Chronic Pain Management Program is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 3/20/08, 4/1/08
ODG Guidelines and Treatment Guidelines
Letter to I-Decisions 4/10/08
Request for Reconsideration 3/24/08
Concurrent Report 3/17/08
Pre-Authorization Request 2/18/08

Texas Administrative Code
Hospital Records 6/28/07
Hospital Operative Report and Hospital Stay Records 7/11- 7/12/07
Range of Motion Studies 12/17/07, 10,18/07
Exam Notes 8/9/07, 12/5/07, 1/8/08, 2/6/08
Prescriptions for Medical Equipment 8/14/07, 9/3/07, 10/19/07, 2/6/08
Chronic Pain Management Program Daily Notes 2008 2/27-29, 3/3, 3/5, 3/12-14, 3/17-18
Pain and Recovery Clinic Daily Progress Notes from 8/9/07-12/19/07
Mental Health Evaluation 1/29/08
Orthopedic Reports 7/11/07, 7/27/07, 8/27/07, 11/1/07, 11/19/07, 12/17/07
Imaging Reports 6/28/07, 7/11/07, 12/7/07, 3/24/08
Work Status Reports 7/3/07- 4/7/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient injured his left wrist and shoulder in xx/xx. He underwent ORIF for a wrist fracture. Shoulder MRI showed bursitis. Wrist x-rays showed healing of the fracture. Further treatment consisted of physical therapy, medications, and a shoulder injection. He has additionally undergone treatment with sessions in a CPMP with improvement in symptoms.

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

Based on the ODG Guidelines and Treatment Guidelines concerning the use of additional CPMP in the treatment of shoulder bursitis and wrist fractures, 10 additional sessions of CPMP are not medically necessary for this patient. He has undergone extensive treatment of his injuries including treatment in a CPMP. By this time, the claimant should be independent, in a self-directed treatment program. It is beyond a degree of medical probability that he will derive substantial benefit from further sessions in a CPMP.

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

- 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)**