

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: September 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of Left Elbow Chronic Pain Management Program

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

Orthopedic Surgeon with Fellowship training in Upper Extremities

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

Denial Letters 6/27/08 and 7/22/08

Records from Dr. 7/31/08 and 9/3/08

Records from Dr. 6/13/08 thru 8/20/08

FCE's 6/18/08, 11/8/07, and 11/6/07

Health 6/18/08

Peer Review 7/19/08

Records from Healthcare System: 11/15/07 and PPE 2/1/08

Record from Dr. 2/14/08

Record from Chronic Pain Management 11/21/07

Record from Diagnostics No Date

Records from Dr. 10/11/06 and 8/27/06

PATIENT CLINICAL HISTORY [SUMMARY]:

HEALTH AND WC NETWORK CERTIFICATION & QA 10/8/2008
IRO Decision/Report Template- WC

The patient has chronic pain, depression, somatization, and causalgia after internal fixation of an elbow fracture. Lower levels of care have been tried with no success. A chronic pain management / functional restoration program has been denied by the insurance company as medically unnecessary.

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

The requested procedures are medically reasonable and necessary for this patient. The patient has failed an adequate trial of medical management including surgery, rehab, and multiple medications. He is unable or return to work at this time. A chronic pain management program that emphasized functional restoration is medically reasonable and necessary for this patient. The patient fits the ODG criteria.

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)**