



514 N. Locust St.
Denton, TX. 76201
Off: (940) 382-4511
Fax: (940) 382-4509
Toll Free: (877) 234-4736

Notice of Independent Review Decision

DATE OF REVIEW: 03/16/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pain Management 5 x week x 2 weeks x 80 hours

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

Board Certified in Pain Management/Anesthesiology

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 or not medical necessity exists for each of the health care services in dispute.

Pain Management 5 x week x 2 weeks x 80 hours - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Consultation/Treatment Planning Evaluation, M.D., 01/21/09
- Examination Evaluation, Ed.D., 01/21/09
- Pre-Authorization for Functional Restoration/Reconsideration, 01/27/09

- Adverse Determination, 02/02/09
- Treatment Planning Evaluation - Physical Therapy, PT, 02/04/09
- Functional Capacity Evaluation (FCE), 02/09/09
- Disability Management System Staffing Note, Spinal Rehabilitation Center, 02/11/09, 02/19/09
- Notification of Reconsideration Determination, 02/18/09
- Patient Demographic Report (No date)

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on xx/xx/xx while pulling a fifth wheel pin, feeling a pop in his right shoulder. Multiple MRI's were performed, injections were administered, and an FCE was accomplished. The patient's most recent medications were noted to be Hydrocodone, Temazepam, Restoril and Diovan.

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

A chronic pain management program, per ODG treatment guidelines and nationally accepted standards of care, is medically reasonable and necessary when all appropriate medical treatment and evaluations have been exhausted. In this case, that is clearly not the situation.

First, despite the psychologist's assertion of the patient having significant depression, there has never been any documented trial of this patient being prescribed an antidepressant, nor has the claimant had any attempt at lesser levels of psychologic care to treat his alleged depression.

Moreover, regardless of any psychologic treatment that may be provided to this patient through either individual psychotherapy or a chronic pain management program, this patient will still have a significant structural lesion of his right shoulder that will continue to be present and act as a severe impediment to his functional status.

Additionally, rotator cuff surgery was offered to the patient to treat the August 2007 injury, which has clearly not been accomplished. Therefore, again, it is readily apparent that this patient has not exhausted all appropriate medical treatment and evaluation to qualify him for admission to a chronic pain management program.

Therefore, since this patient has not exhausted all appropriate medical treatment and evaluation for his right shoulder, this patient is not an appropriate candidate for admission to a chronic pain management program. He has not had appropriate trials of antidepressant medication, nor of lesser levels of psychologic care. He will continue to have the severe structural abnormalities in his right shoulder regardless of attendance at a chronic pain management program, structural abnormalities which will continue to be a severe impediment to his functioning and a continuing contributor to his pain. No

amount of psychologic treatment, physical therapy, or rehabilitation will repair that structural damage or significantly decrease the significance of their presence.

Therefore, there is no medical reason or necessity for the requested ten sessions of a chronic pain management program. The recommendations by two separate physician advisors for non-authorization of this request are, therefore, upheld by this decision.

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)