

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5x/week x 2 weeks (8 hours/day) neck, right shoulder
97799

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

M.D., Board Certified Orthopedic Surgeon

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

ODG Guidelines

Psychological evaluation, 06/09/09

Chronic pain management program / progress notes, 08/03/09 to 08/19/09

Chronic pain management program / behavioral health progress note, 08/13/09

Peer Review, 08/31/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female who reportedly injured her shoulder and neck on xx/xx/xx . The records indicated that the claimant had right shoulder pain and diagnosed with a frozen shoulder. The claimant was treated conservatively with medications, physical therapy and injections and later was determined to be a good candidate for a chronic pain program. Chronic pain management notes dated 08/03/09 to 08/19/09 and behavior health progress notes dated 08/14/09 and 08/19/09 indicated the claimant was anxious to return to work and actively participated in group therapy sessions and coping skills and appeared to be making progress in the program. The records indicated that the claimant had attended approximately nine pain management sessions as of 08/19/09. Chronic pain management program five times a week for two weeks to the neck and right shoulder has been requested.

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

This claimant was deemed psychologically appropriate for chronic pain management and

indeed it appears that nine sessions were provided between 08/03/09 and 08/19/09. Records would suggest unremarkable electrodiagnostics.

The claimant's progress with chronic pain management therapy to date is a bit unclear, from the notes provided. The ODG Guidelines would outline that beyond two weeks, efficacy must be documented by subjective and objective gains, before the authorization of further visits, not to exceed twenty. No such documentation is present in this case. As such I am not able to recommend as medically the proposed additional chronic pain management visits for a total of ten additional visits. The reviewer finds that medical necessity does not exist at this time for Chronic Pain Management Program 5x/week x 2 weeks (8 hours/day) neck, right shoulder 97799.

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)