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Notice of Independent Review Decision

DATE OF REVIEW: 4/1/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include the medical necessity of the continuation of a chronic pain management program times 10 sessions.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has practiced for greater than 15 years and performs this type of procedure in practice.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of the continuation of a chronic pain management program times 10 sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
xxxxx and xxxxx.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxxx: 1/29/10 denial letter, 2/16/10 denial letter, multiple guidelines/studies (regarding CPM programs), 3/15/10 IRO summary, 11/3/09 IRO report by xxxxx, 3/21/09 DWC 1, 5/19/09-5/21/09 PLN11, 3/17/09 Associate statement, various DWC 73 forms, scripts from MD, progress notes by Dr. 3/21/09, 3/23/09 DWC 6, 3/23/09 to 6/15/09 handwritten notes (unknown party), disability certificate and script 3/23/09, 4/8/09 to 5/26/09 notes by MD, 4/28/09 plan of PT care, 5/19/09 right shoulder MRI report, 5/27/09 to 1/13/10

reports by MD, daily progress notes from xxxxx 6/10/09 to 9/21/09, DD report of 7/13/09, 7/16/09 neurodiagnostic report, LMN 9/23/09 to 9/24/09, 10/9/09 report by MD, 10/9/09 MMT and ROM report, mental health eval 11/24/09, 11/24/09 discharge summary, 11/30/09 FCE report, massage therapy notes 1/27/10, CPM daily (progress) notes 12/18/09 to 1/27/10, CPM group notes 12/22/09 to 1/27/10, 1/26/10 10 day treatment extension request letter by, BSW, 1/5/10 progress summary by, 12/11/09 preauth request and 2/10/10 request for reconsideration letter.

xxxxx: 3/15/10 letter Dr..

We did receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx while working. He was taking down pallets, and as he reached and began the activity, there was a popping in his shoulder, resulting in pain in and around the shoulder and neck area. He was treated initially with medication and then prescribed physical therapy. After four weeks of physical therapy, he had MRI studies of the shoulder, where it was noted that there was an injury with resulting rotator cuff area injury. A full-thickness tear of the supraspinatus with retraction of approximately 2-3 inches was noted on the right side. He underwent a surgical evaluation, which apparently determined that secondary to his age and general health status, he did not wish to pursue surgery. He then was placed in a multidisciplinary chronic pain management program, where he underwent a pre-authorized program of 20 visits. An additional ten treatment sessions were requested and denied.

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

Utilizing the ODG criteria to determine the medical necessity of exceeding the twenty already-provided treatment sessions of a chronic pain management program, the current request does not indicate meeting criteria to exceed the recommended twenty treatment sessions as follows. There is a discrepancy in the documentation of various daily treatment sessions and the summary statements made in the pre-authorization request for the request currently in dispute. Noting in the pain management group session monitoring forms, there is no indication for multiple treatment dates that the patient showed any sustainable decrease in his pain complaints below a level of 8 or 9/10. There is no quantitative indication of documentation to indicate the patient as gaining in functional level of activity improvement. The patient was not weaned off of his medication use, as proposed in the original treatment plan. By the nature of his injury with a significant tear with tendon retraction involving the right rotator cuff, there is no reasonable medical probability that his overall function or pain symptoms will be significantly altered, as there has been a decision of no surgical

repair that would provide the opportunity for mechanical improvement in his condition.

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)