

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive, #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5 x Week x 2 Weeks (10 Sessions)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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 and Treatment Guidelines
Adverse Determination Letters, 12/21/09, 1/4/10
Pain & Recovery Clinic 1/27/10, 12/23/09, 12/16/09,
5/27/08, 6/12/08, 7/1/08, 7/14/08, 10/10/07, 11/19/08, 11/6/07, 3/7/08,
4/4/08, 4/14/08
LPC, 12/8/09, 5/20/08
DR., 8/16/07, 9/25/07
PT Notes, 2007
Dr., MD, 10/3/08
Dr., MD, 10/15/08
MRI Left Knee, 8/23/07
Radiology, 10/5/07
Electrodiagnostic Evaluation, 10/30/07
MD, 10/29/07, 1/8/08, 12/31/07
Clinic, 12/28/07

PATIENT CLINICAL HISTORY SUMMARY

This is a woman reportedly injured on xx/xx/xx with injuries to her left shoulder, elbow, wrist, knees, and cervical spine. MRI showed no abnormalities of the knee, but she underwent knee surgery in 2008. She did not improve. She underwent a subsequent meniscectomy for a posterior horn tear in 2009. She underwent left shoulder surgery in 9/09 by Dr.. Her cervical

MRI showed cervical disc bulges, without frank herniation. She had foraminal stenosis at C5/6 and C6/7. An EMG done 3 months post injury was interpreted as showing a chronic C5 radiculopathy limited to the dorsal scapula nerve. She had no improvement with cervical injections. The Physical Therapy notes in 2007 noted her poor compliance at. She was in a pain program in 2008. Ms. described some of her psychological testing as in the high dysfunctional range. There were high scores on the Fear Avoidance and BPI.

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

Records indicate significant psychological issues present in this patient. While she has participated in a pain program and had psychological treatment, records indicate she has regressed or worsened. She has a knee operation after a normal knee MRI. She has had shoulder surgery. The cervical MRI showed degenerative changes that preexisted the injury. The electrodiagnostic studies were read as a chronic C5 radiculopathy, although isolated to a single nerve that can be involved with shoulder pathology. The provider has not provided evidence of the patient's motivation to change. The ODG allows a single 10-session pain management program with an extension if progress is demonstrated. According to the records, the patient did not demonstrate progress, but rather she regressed. The patient does not meet the criteria established in the ODG for further pain management. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program 5 x Week x 2 Weeks (10 Sessions).

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)