

9I-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:

Jun/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pain Management 5xwk x2wks 80 hrs Rt shoulder/neck 97799

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

MD, Board Certified in Internal Medicine

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, 3/26/10, 4/22/10
Healthcare System 3/10/10
Rehab Center 3/19/10, 4/5/10
2 3/10/10
1/23/09
MD 2/24/09
Family Medicine 3/2/10, 2/15/10, 1/18/10, 12/16/09, 4/9/09
D.O. 3/26/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female patient who was injured at work when a client grabbed her hair and shook her head from side to side. Cervical MRI showed minimal changes with no evidence of acute injury. Electrodiagnostic testing showed no radiculopathy. Physical examination showed normal neurological findings. She underwent a course of physical therapy, completing 22 sessions.

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

I have reviewed the Official Disability Guidelines concerning the use of chronic pain management programs (CPMP) in the treatment of soft tissue injuries of the cervical spine, such as in this case. There is little evidence to support the use of these programs over other methods of rehabilitation. The ODG for chronic pain recommends the program when there is

evidence that a complete diagnostic assessment has been made, and this has not been accomplished in this patient's case. In addition, it is not clear if all previous methods of treating the chronic pain have been unsuccessful with an absence of other options. Specifically, it is not clear if the patient has had any behavioral therapy. Based on the records reviewed, the reviewer finds it is beyond a degree of medical probability that the claimant would derive substantial clinical benefit from the proposed treatment. The reviewer finds that medical necessity does not exist at this time for Pain Management 5xwk x2wks 80 hrs Rt shoulder/neck 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)