

SENT VIA EMAIL OR FAX ON  
Jul/14/2010

# Applied Resolutions LLC

An Independent Review Organization  
1124 N Fielder Rd, #179  
Arlington, TX 76012  
Phone: (512) 772-1863  
Fax: (512) 853-4329  
Email: manager@applied-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/14/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management 80 hours

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

Chiropractor  
AADEP Certified  
Whole Person Certified  
Certified Electrodiagnostic Practitioner  
Member of the American of Clinical Neurophysiology  
Clinical practice 10+ years in Chiropractic WC WH Therapy

**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**

OD Guidelines  
Denial Letters 6/1/10 6/15/10  
Dr. 9/10/09 thru 5/25/10  
Dr. PhD 6/9/10 thru 6/20/10  
Work Comp Eval 8/11/09  
Impairment Rating 2/19/10  
Accident & Injury Rehab 10/30/09 thru 5/2/10  
FCE 1/11/10 and 2/8/10  
Dr. 8/26/09 thru 2/1/10  
MRI 6/5/09

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee was involved in an occupational injury on xx/xx/xx when he was working as a xxxx. The injured employee was injured when he fell as he was exiting the rear of the truck and landed on his right side and right shoulder. The injured employee was sent to the ER. The injured employee had a right shoulder arthrogram and post arthrogram MRI. The injured employee eventually underwent a right shoulder arthroscopy, glenoid labrum SLAP repair, and excision of distal clavicle, acromioplasty, and rotator cuff repair on 10-22-2009. The injured employee had post operative physical therapy. The injury employee had a FCE 1-11-2010 and 2-08-2010. The injured employee has completed work hardening/conditioning program. The injured employee has complete 10 days (80 hours) of chronic pain management and an additional 80 hours are now being requested at this time. The injured employee takes Wellbutrin 350mg and Trazodone 5mg daily, no medication response was noted. Additionally, the injured employee was on Chantix, which is known to cause sleep disorders. The initial psychological assessment was BAI=5 and BDI=11 and after 10 sessions BDI=9 and BAI=7. Post CPM the injured employee has meet short term goals for cardio, box lift, unilateral carry, non-material handling, identified a RTW plan, increased sleep hours, decreased VAS pain ratings, decreased McGill score from a 8 to a 6, and established long term goals.

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

The injured employee has completed the initial trial of 80 hours of chronic pain management. The injured employee was initially approved for 80 hours CPM and an additional 80 hours have been requested. The additional 80 hours would require the provider to show evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The injured employee has been 100% compliant and sufficient documentation has been submitted to provide evidence of subjective and objective gains. Therefore, the injured employee does meet the requirements for an additional 80-hours of CPM.

**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)