

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 Days of Chronic Pain Management Program

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, 2/22/10, 3/23/10

Injury 1 2/16/10, 3/15/10, 1/20/10, 2/2/10, 1/12/10, 3/19/10, 3/2/10,
1/22/09

PPE 1/14/10

Health 9/24/09, 10/2/09, 10/15/09, 10/8/09, 10/27/09, 12/18/09

Diagnostics 1/14/10

Impairment Rating 10/30/09, 2/19/10

M.D. 12/14/09

Clinic 7/9/09, 8/4/09, 12/16/09, 10/15/09,
9/16/09

R.N. 11/4/09

3/22/10

D.C. 7/31/09, 7/29/09, 7/27/09

Diagnostic 8/17/09, 8/25/09

Diagnostic Center 8/29/09, 8/31/09, 8/18/09

M.D. 8/31/09

Surgical Associate 9/22/09

Imaging 1/19/10

D.O. 10/27/09, 9/29/09, 11/24/09, 12/22/09

M.D. 11/24/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured on xx/xx/xx while assisting a patient. She developed neck, low back, abdominal and right upper extremity symptoms. She did not improve with PT. She had electrodiagnostic studies showing bilateral CTS, worse on her asymptomatic left side. There were signs of tendinosis on the shoulder MRI. The cervical MRI showed a disc protrusion at C6/7 and a left C5/6 paracentral one. The lumbar MRI showed bulges at L3 to S1. There was no evidence of nerve root compromise. One reviewer reported a note about an abdominal hernia. She had a prior history of an adjustment disorder with depression, anxiety and pain after an MVA. It improved. She was described as not moving her right upper extremity by Dr. in 12/09. There were other notes about her keeping her hand flail. Her FCE showed her to be at a light PDL, when her job requires a heavy program. Dr. during his DD exam noted that her anxiety and depression would need to be addressed before she would be able to work. She had 12 sessions of psychotherapy and had minimal improvement with her pain, but worsening with her depression and anxiety. She is not a surgical candidate.

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

This request is for 10 sessions of a chronic pain program. The claimant has not done well with the psychotherapy to date, and has preexisting issues. She has complaints of burning dysethesias. She has lack of use of the hand. However, all diagnostic work up has been completed, and there are no other treatment methods to offer according to the records. The claimant is reportedly motivated to work. She did improve with treatment of the psychological issues after the MVA. There is no structural problem identified. The records show that this woman has shown evidence of motivation to improve and return to work. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. Based on the records and the ODG, the reviewer finds that medical necessity exists for 10 Days of Chronic Pain Management Program.

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)