

SENT VIA EMAIL OR FAX ON
Apr/04/2011

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 10 sessions

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

Board Certified PMR and 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

OD Guidelines

1. Cover sheet and working documents
2. Response to denial letter dated 02/10/11, 12/03/10
3. Patient treatment goals and objectives dated 02/07/11
4. 90801 evaluation dated 01/18/11, 10/07/10
5. Physical performance evaluation dated 08/09/10
6. BHI2 report dated 01/06/11
7. Medical records Dr.
8. Mental health evaluation/treatment request
9. Radiographic report left hand dated 02/25/10
10. MRI left shoulder dated 11/04/09, 07/20/09
11. CT left elbow dated 07/20/09
12. CPMP individualized daily treatment plan and program description dated 02/07/11
13. Patient face sheet
14. Utilization review determination dated 02/10/11, 02/16/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was changing a conveyor belt roller on a ladder but when tightening a screw, it broke and he fell off the

ladder and landed on the left side of his head, face, neck and shoulder. MRI of the left shoulder dated 07/20/09 revealed no evidence of rotator cuff tear. CT of the left elbow dated 07/20/09 revealed supracondylar fracture of the distal humerus with approximately 4-5 mm of distraction of fracture fragments. MRI of the left shoulder dated 11/04/09 revealed evidence of a small non-retracted SLAP-type labral tear. Radiographs of the left hand dated 02/25/10 revealed shattered-comminuted fracture involving the index finger middle phalanx with intraarticular extension into the proximal and distal interphalangeal joint spaces. Follow up note dated 08/02/10 indicates that the patient is status post ORIF for left supracondylar fracture of the left elbow on 07/23/09 and has been diagnosed with a left shoulder strain with a small SLAP type lesion.

Physical performance evaluation dated 08/09/10 indicates that treatment to date includes medication management, TENS unit, cortisone injections and physical therapy. Current PDL is sedentary-light and required PDL is medium. Psychological evaluation dated 10/07/10 indicates that BDI is 32 and BAI is 22. Diagnosis is adjustment disorder with mixed anxiety and depressed mood. Psychological evaluation dated 01/18/11 indicates that medications include Zanaflex and Anaprox. BDI is 32 and BAI is 22. Diagnoses are adjustment disorder and pain disorder.

Initial request for chronic pain management was non-certified on 02/10/11 noting that there is no indication that narcotic medication is required for management of pain symptoms. There is insufficient documentation that lesser levels of care have been attempted. The denial was upheld on appeal on 02/16/11 noting that there is no report regarding exhaustion of conservative modes of treatment. Current reliance on medications is minimal in terms of no requirements of controlled substances.

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

Based on the clinical information provided, the request for chronic pain management 10 sessions is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent ORIF for left supracondylar fracture of the left elbow on xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto since the date of surgery submitted for review. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no indication that the patient has undergone a course of individual psychotherapy. The patient is not currently taking any narcotic medication for management of pain symptoms. Given the current clinical data, the requested chronic pain management is not indicated as medically necessary, and the two previous denials are upheld.

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)