

US Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 10 days

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
Board Certified in Electrodiagnostic 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 Pain Chapter
6/21/11, 7/18/11
Injury 1 3/9/11 to 8/12/11
MD 5/4/11
Evaluation Center 5/4/11 to 6/28/11
DO 6/21/11
MD 4/22/11

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who fell at work on xx/xx/xx. She apparently dislocated her shoulder and required subsequent surgery (8/10) for decompression, acromioplasty and SLAP and rotator cuff tears. She apparently improved enough to return to work at a different position. She stopped after 4 months, presumably due to pain, but that was not clear in the records. Her job required her to be at a medium heavy PDL and her functional level in June 2011 was reported as sedentary to light.

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

This woman has impaired function with pain, depression and anxiety. Her fear quotient is high. There are no underlying addiction or psychopathology issues according to the records provided. She has some depression, but it appears to be reactive. According to the records, psychological intervention has been denied. She has exhausted other treatments including physical therapy and surgery. Her motivation is such that she was indeed able to work for 4 months before stopping. The only other unutilized treatment would be psychological

intervention, and that was denied. From what the reviewer can determine from the records, the remaining option for this woman is a chronic pain program. There are no contraindications in this patient's history after review of the ODG criteria. The reviewer finds that medical necessity exists for Chronic Pain Management Program x 10 days.

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)