

# Prime 400 LLC

An Independent Review Organization  
8760 A Research Blvd., #241  
Austin, TX 78758  
Phone: (530) 554-4970  
Fax: (530) 687-9015  
Email: manager@prime400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/28/2011

**IRO CASE #:**

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

Chronic Pain Management of five times a week for two weeks to the right shoulder for a total of 80 hours (97799)

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

M.D., Board Certified Anesthesiology/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

10/13/11, 08/31/11

Progress note dated 09/16/11

Appeal letter dated 09/09/11

Office visit note dated 08/17/11, 08/15/11, 07/29/11, 08/16/11

Partial mental health evaluation (undated)

MMI/IR evaluation dated 05/19/11

Electrodiagnostic testing dated 07/12/10

Operative report dated 10/27/10

Toxicology report dated 09/06/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. She was lifting a with a coworker. Both of her arms were jerked downwards. She has had physical therapy, diagnostic testing, right shoulder surgery in October 2010, several injections, and nerve block and medication management. MMI/whole person impairment rating dated 05/19/11 indicates that the patient reached MMI as of this date with 0% whole person impairment. A partial mental health evaluation (undated) indicates that BDI is 26 and BAI is 31. Diagnoses are chronic pain disorder associated with both psychological features and general medical condition, and major depressive disorder recurrent.

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

This patient has been placed at maximum medical improvement as of 05/19/11 with 0% whole person impairment. There is no current functional capacity evaluation submitted for

review to establish baseline levels of functioning as well as current versus required physical demand level. The submitted records fail to establish that the patient has exhausted lower levels of care and are an appropriate candidate for CPMP. The patient has been diagnosed with major depressive disorder; however, there are no individual psychotherapy notes submitted for review. Additionally, the previous reviewer reports that the patient has completed a previous chronic pain management program from 04/25/11-05/25/11. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. The reviewer finds no medical necessity for Chronic Pain Management of five times a week for two weeks to the right shoulder for a total of 80 hours (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)