

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/05/2011

**IRO CASE #:**

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

10 Chronic Pain Management visits

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

M.D., Board Certified Physical Medicine and Rehabilitation and Pain 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**

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female who reportedly was injured on xx/xx/xx. The mechanism of injury is not described, but the patient is noted to have undergone two surgeries to the left wrist/arm including removal of hardware on 06/29/11. She rates her pain as 7-8/10, and current medication is Etodolac. GAF score was noted as 59; diagnoses are pain disorder associated with both psychological factors and a general medical condition, also noted is adjustment disorder with anxiety. As part of the utilization review, the case was apparently discussed with Dr. and the patient's injury was a distal radius fracture with ORIF and hardware removed in June 2011. The patient was noted to have undergone physical therapy x 6 postop visits. A functional capacity evaluation performed 09/08/11 showed the patient to be at a sedentary physical demand level with no use of the left arm. Her regular job as requires a medium physical demand level. A chronic pain management program has been recommended by her provider.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

**AND CONCLUSIONS USED TO SUPPORT THE DECISION**

This female patient sustained an injury to the left upper extremity with distal radius fracture requiring ORIF and subsequent hardware removal. As noted in a previous review, only the last page (page 8) of a psychological evaluation was submitted for review. There is no documentation that the claimant has exhausted lower levels of care prior to progressing to a multidisciplinary chronic pain management program. Moreover, progress note dated 10/03/11 from Dr. indicates that this patient is a candidate for further invasive treatment including injection of the distal radioulnar joint. ODG does not recommend CPMP if there are other options likely to result in significant clinical improvement. Because the treatment guidelines have not been satisfied, the reviewer finds that there is not a medical necessity at this time for 10 Chronic Pain Management visits.

**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 KNOWLEDGBASE

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)