

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

90862, Ultram ER 100 mg Daily PRN for pain

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

M.D., Board Certified Orthopedic Surgery

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

Official Disability Guidelines, Pain

Official Disability Guidelines, Shoulder

Request for IRO dated 11/10/11

Utilization review determination dated 09/12/11

Utilization review determination dated 10/07/11

Clinical records Dr. dated 06/09/05

Clinical records Dr. 06/17/05-07/15/11

MRI shoulder dated 06/17/05

EMG/NCV study dated 10/31/05

Impairment rating dated 01/20/06

Operative report dated 09/25/07

Operative report dated 03/20/08

Peer reviews Dr. dated 06/30/08, 10/01/08

Peer review report dated 01/11/11

Letters from Patient, 9/20/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured while employed as. She developed severe pain in left shoulder with limitation in range of motion. She was initially seen at Clinic where x-rays were taken. She was put on physical therapy program and allowed to return to work on restricted duty. The claimant was referred to Dr. on xx/xx/xx. At this time the claimant is noted to have positive impingement sign of left shoulder. She cannot elevate her arm beyond 90 degrees. There is no neurovascular deficit. She received corticosteroid injection. MRI of the shoulder was performed on xx/xx/xx. This study shows severe tendinopathy of supraspinatus tendon, short to low moderate grade intrasubstance tear involving the anterior supraspinatus tendon and low grade tear involving the infraspinatus tendon. There is severe

tendinopathy of the biceps tendon with findings consistent with tenosynovitis. There is increased subdeltoid subacromial bursal fluid space consistent with previously performed injection. There is moderate AC Joint degenerative arthropathy. There are degenerative subcortical marrow signal changes. There is some evidence of degeneration or subtle tearing of the labrum. Records indicate the claimant continued under the care of Dr. receiving extensive physical therapy and corticosteroid injections. She is later reported to have positive findings on examination for carpal tunnel syndrome. She was referred for EMG/NCV of upper extremities, which was reported as normal. On 10/31/05 records indicate Dr. placed the claimant at MMI on 01/20/06. She continued to have complaints.

She was taken to surgery on 09/25/07 and underwent a left carpal tunnel release with extensive postoperative therapy. She had continued complaints of shoulder pain, and on 03/20/08 she underwent a decompression, acromioplasty, excision of subacromial bursa, and coracoacromial ligament and repair of rotator cuff tear. The record includes peer review performed by Dr. dated 06/30/08, 10/01/08. Records indicate the claimant has continued limited range of motion of left shoulder. She is reported to have minimal sensory loss in 3 ½ digits of left hand. The most recent clinic note is dated 07/15/11. The claimant's physical examination is unchanged. She was continued on Ultram ER. The record includes letter of appeal from the claimant. Dr. performed the initial review on 09/12/11. Peer to peer was conducted with Dr.. He noted the request for Ultram was non-certified due to lack of current documentation. His most recent clinical information submitted for review was dated 03/10/09. At the time of submission, the additional clinical information had apparently not been received. Dr. performed subsequent appeal request on 10/07/11. Dr. noted that there is insufficient clinical information, including no documentation that these prescriptions are from single practitioner and that they are being taken as directed, and lowest possible dose is being prescribed.

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

The available medical record indicates this claimant developed shoulder pain while working as an. She was initially diagnosed with shoulder injury, which was treated with oral medications, injections, and physical therapy. She is later reported to have developed carpal tunnel syndrome for which she underwent carpal tunnel release despite having normal EMG/NCV study. She has further received treatment to her shoulder ultimately resulting in surgical intervention, which was performed on 03/20/08. Postoperatively, she has had continued subjective complaints of pain with reduced range of motion. She is reported to have chronically been maintained on Ultram ER 100 mg daily. The most recent clinic note submitted for review is dated 07/15/11. This note does not provide detailed physical examination, nor does it document if the claimant has routinely undergone urine drug screening for compliance. The record does not document that the continued use of Ultram ER results in significant increases in functional activity levels. This patient has not been examined since 07/11. Based on lack of current clinical information and data to establish efficacy for continued use of this medication, the reviewer finds the request for 90862, Ultram ER 100 mg Daily PRN for pain is not medically necessary.

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)