

I-Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions/days of an interdisciplinary chronic pain rehabilitation program

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

MD, Board Certified Psychiatrist

American Board of Psychiatry and Neurology

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 claimant is a xx-yr-old female who slipped and fell on a wet floor. She sustained multiple fractures and underwent surgery and later had the hardware removed. The most recent medical evaluation in the record is an orthopedic follow up note dated 12/09/2010. Dr. notes the patient continues to complain of pain in her right foot and right ankle. She states that the skin turns cold and she sweats excessively. She cannot tolerate cold and continues to complain of hyperesthesia and stiffness at the ankle joint. Physical findings are minimal. The assessment is that she has either complex regional pain syndrome, right foot and ankle or causalgia. The doctor has recommended an EMG of her lower limbs to determine if she does have nerve damage in her right foot and ankle. A request was also made for 10 sessions of CPMP on 12/01/2010. The evaluation included a clinical interview, BDI, and BAI. The BDI showed moderate range of depressive symptoms and the BAI showed moderate range for anxiety symptoms. The request was denied. The rationale for the denial was that there was not an adequate and thorough multidisciplinary evaluation to determine the appropriateness of this request and that all diagnostic procedures necessary to rule out treatable pathology had not been performed.

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

The reviewer finds no medical necessity at this time for 10 sessions/days of an interdisciplinary chronic pain rehabilitation program. In this case, it appears that the evaluation is incomplete and that all diagnostic procedures have not yet been performed. The note dated 12/09/2010 is clear that the physical problems are still being evaluated and treatment decisions will be based upon those findings. With regards to the incomplete evaluation, it is interesting to note that in the patient's file is a similar evaluation dated

09/09/2010. The evaluation of that date and the evaluation dated 12/01/2010 are absolutely identical except for the recommendations. The evaluation dated 09/09/2010 recommends individual psychotherapy and the evaluation dated 12/01/2010 recommends CPMP. ODG is very specific about the criteria for these types of programs. The limited information provided is insufficient to justify the medical necessity for 80 hours of CPMP. Additionally, although the initial sessions of IP are recommended, there is no evidence in file to show if this was provided to the patient or not. For these reasons, upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be 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)