

SENT VIA EMAIL OR FAX ON
Jul/11/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 4 x wk x 2.5 wks., Right Shoulder

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

Board Certified Anesthesiologist/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

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 05/19/11, 06/16/11
3. Initial assessment and evaluation dated 05/09/11
4. Functional capacity evaluation dated 05/09/11, 02/22/11
5. Handwritten progress note dated 05/04/11
6. Reevaluation dated 03/29/11
7. CT right shoulder dated 12/08/10
8. MRI right shoulder dated 12/22/10
9. Designated doctor evaluation dated 04/11/11
10. Work hardening progress report dated 03/28/11
11. Initial office visit dated 03/08/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient picked up a

box and turned around when he lost his balance and fell down. CT of the right shoulder dated 12/08/10 revealed complex fracture of the anterior inferior glenoid and an additional fracture of the coracoid of the scapula. Functional capacity evaluation dated 02/22/11 indicates that required PDL is heavy and current PDL is light. Treatment to date includes 12 sessions of physical therapy and a work hardening program. Work hardening progress report dated 03/28/11 indicates that current PDL is light/medium. Designated doctor evaluation dated 04/11/11 indicates that the patient is not at MMI, but will be once therapy is completed. Functional capacity evaluation performed on this date indicates that current PDL is medium. Functional capacity evaluation dated 05/09/11 indicates that current PDL is light. Psychological evaluation dated 05/09/11 indicates that BAI is 10 and BDI is 17. Current medications include Hydrocodone and ibuprofen.

Initial request for chronic pain management program was non-certified on 05/19/11 noting that there is no objective documentation that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The patient has a history of high blood pressure; however, there is no documentation that addresses this medical issue that is considered to have an impact on the success of the contemplated program. There are no specific medication extinction goals. The denial was upheld on appeal dated 06/16/11 noting that there is no documentation that previous methods of treatment have been unsuccessful. There are no physical therapy or individual psychotherapy progress notes submitted for review. There is nothing that addresses the patient's hypertension.

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

Based on the clinical information provided, the request for chronic pain management program 4 x wk x 2.5 wks, right shoulder is not recommended as medically necessary, and the two previous denials are upheld. The patient completed two weeks of a work hardening program with significant improvement noted. There is no documentation that there is an absence of other options likely to result in significant clinical improvement. The patient has reportedly undergone individual psychotherapy; however, there are no progress notes submitted for review. The patient has a history of high blood pressure; however, nothing in the submitted records addresses this medical issue.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES