

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/30/2011

**IRO CASE #:**

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

Chronic Pain Management Program (CPMP) x 10 days

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

MD, Psychiatrist

Board Certified by the 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**

Official Disability Guidelines

Direct 4/27/11, 5/20/11

of Dallas 3/28/11 to 6/15/11

5/4/10

Evaluation Center 4/14/11

M.D. 4/14/11

Behavioral & Mental Health 6/22/10

Diagnostic Imaging 7/31/08

Surgery Center 11/9/07

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a man who injured his left shoulder at work on xx/xx/xxxx. He subsequently underwent left rotator cuff repair and has had intermittent levels of pain since then. His last physical exam was on 04/14/2011 by Dr. M.D. He noted pain in the left shoulder on range of motion in all directions, and he is unable to raise the left arm above his shoulder in any direction without severe pain. He had mild compression pain over the posterior shoulder on the left. Dr. had no further treatments to recommend other than enrollment in CPMP. He underwent psychological testing on 06/22/2010 including MMPI-2. He has moderate depression on DBI-II, fear-avoidance of activities at home and at work and moderate disabled self-identity on the Oswestry Disability Index. His only medication is Naproxen 500 mg 3-4 times/week. He was terminated from his job in 12/2009. He has worked in temporary positions subsequently but is unable to secure a full-time position. The request for CPMP was denied initially by the insurance company reviewer who stated that the treatment team had not performed an adequate and thorough evaluation. The reviewer noted psychological testing performed 03/28/2011 and 04/14/2011, but did not reference the MMPI from 2010. The second reviewer denied the request stating that the treatment team could not account for "what the patient did from 2008 to 2010 as there is a significant gap in treatment during that time." The reviewer also stated "There is little information regarding why he was terminated,

why he was not able to work elsewhere if he was able to work until 12/09 and why he was not apparently had active treatment since 2008.”

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The rationale that an inadequate evaluation has been made is not supported by the records. The treatment team has written an appeal letter that explains the claimant's previous evaluations. The record supports the treatment team's assertions that an adequate medical and mental evaluation has been completed, and no further treatments, other than CPMP, have been recommended. The claimant has a good prognosis for improvement as judged by ODG criteria. The treatment goals are presented by the treatment team as required by ODG in cases in which the injury occurred more than 24 months prior to treatment. The reviewer finds there is medical necessity for Chronic Pain Management Program (CPMP) x 10 days.

**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)