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Notice of Independent Review Decision

**DATE OF REVIEW: 6/11/201**

**IRO CASE #:**

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

Chronic Pain Management x 10 days CPT 97799

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

**D.O. Board Certified in Anesthesiology and 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**

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	5/27/2011
Utilization Review Determinations	4/13/2011-5/10/2011
Rehabilitation Clinic	3/24/2011
Comprehensive Care Plan	3/24/2011
Psychological Diagnostic Interview	4/25/2011
Request Reconsideration	
Functional Capacity Evaluation	3/24/2011
M.D. Medical Report	12/01/2010
Imaging Center Imaging Report	12/02/2010
MRI, LLC MRI Left Shoulder Report	12/22/2010
M.D. Clinical Note	2/11/2011

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female injured on the job xx/xx/xx. Patient sustained injury to the leg, arm and shoulder. Patient has been treated conservatively with medication to include, but not limited to: Ibuprofen, Ultram and Soma. Psychiatric evaluation showed patient experiencing severe depression and anxiety symptoms. Functional capacity evaluation showed decreased range of motion in the left shoulder, weakness in the left arm, and decreased ability to lift with the left arm. Patient had a CT of chest and ribs that was essentially normal, MRI of the left shoulder showed significant thinning over two to three millimeter portion of the distal third of the Rotator Cuff typical of partial tear. Patient was seen by Dr. (ortho), his impression: contusion/strain left shoulder, and adhesive capsulitis of left shoulder. Dr. recommendation was aggressive physical therapy. Patient underwent physical therapy and showed modest improvement. Presently, they are requesting chronic pain management x 10 days.

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

Chronic pain management x 10 days is not recommended.

1. No diagnostic/therapeutic injections were performed.
2. No narcotic therapy was tried, patient only tried Ultram, Ibuprofen and Soma.
3. No sufficient multidisciplinary evaluation performed.
4. Not very well defined pathology.
5. Treatment not sufficiently aggressive.

References: ODG guidelines: Chronic Pain Program Chapter (functional restoration program).

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

- ACOEM- AMERICAN 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