

SENT VIA EMAIL OR FAX ON  
Feb/25/2011

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/21/2011

**IRO CASE #:**

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

Chronic Pain Management 5 X 2 8 hours a day

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

AADEP Certified

Whole Person Certified

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

Chiropractor

**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

Healthcare System 8/24/10

Work Conditioning Program 9/29/10

Rehab Center 12/11/10 and 12/17/10

Pain Scale 12/1/10

BHI2 8/24/10

Medical Center 9/15/09 thru 9/8/10

PPEs 8/24/10 and 7/27/10

MRI /109/09

OP Report 11/16/09

12/29/10 and 12/16/10

#### **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee was involved in an occupational injury on xx/xx/xx while working for as a xxxx. He was apparently lifting 3'x4' sheets of glass while standing in the back of a truck when he felt a pull in his right shoulder. An MRI of the right shoulder was performed on 10/09/09 and reported a full thickness tear of the rotator cuff, tear of the glenoid labrum, tear long head of biceps, and impingement. The injured employee eventually underwent a right shoulder rotator cuff tear, impingement, and labral tear repair on 11/16/09. The injured employee had undergone physical therapy, chiropractic adjustments, ultrasound, massage therapy, exercise therapy, stretching, heat/ice therapy, topical analgesics, acupunctures, FCE/PPE, pain/steroid injections, individual counseling, and work conditioning. The injured employee takes Tramadol 50mg po qd, Skelaxin 800mg po qd, and Diclofenac 75mg po qd and reports that the medication is not related to the current injury. Psychological evaluation indicated that the injured employee is experiencing psychological distress manifested by anxiety, depression, sleep disturbance, and preoccupation with functional deficits and chronic debilitating pain. Beck Depression Inventory (12) indicating mild depression, Beck Anxiety Inventory (34) indicating severe anxiety, McGill Pain Questionnaire (32), Mankoski Pain level (4), Sleep 3-4 hours, and BHI (2). Psychological evaluation stated that the injured employee has excessive dependence on family members, secondary physical deconditioning, and withdrawal from social activities, psychological sequelae, use of and pain medication. The treating physician has is requesting a trial of 10 sessions of chronic pain management.

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

The injured employee currently does meet the required guidelines for a trial of 10 sessions of chronic pain management. Medical records provided support the request for 10 sessions of chronic pain management. The injured employee has exhausted lower level care, has chronic pain syndrome beyond 3 months (#1), loss of ability to function (#2) as indicated by FCE/PPE, treatment of chronic pain has been unsuccessful (#3), the injured employee has surgery and is not a candidate for further surgical procedures (#4), adequate and thorough multidisciplinary evaluation has been made (#5) with psychological testing, FCE/PPE, patient exhibits motivation to change (#6) the injured employee takes medication which is not related to current injury as indicated in report, negative predictors of success above have been addressed (#7) in request / treatment plan, (#8) the program may be used for both short-term and long-term disabled patients, treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy (#9) as indicated by 10 sessions being requested, (#10) total treatment duration should generally not exceed 20 full-day sessions as indicated by 10 sessions be requested, and finally at the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (#10). The request is 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 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)