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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program 5 x week x 2 weeks (80 hours) for the right shoulder 97799

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

MD, Board Certified Physical Medicine & Rehabilitation 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

Official Disability Guidelines

Utilization review determination dated 04/11/11, 04/29/11

Request for services dated 03/22/11

Functional capacity evaluation dated 03/23/11, 09/22/10

Handwritten daily progress note dated 02/01/11, 02/02/11, 02/03/11, 01/28/11, 02/21/11, 02/24/11

Individual progress note dated 02/24/10, 03/02/10, 03/10/10, 03/15/10, 03/17/10

Letter of medical necessity dated 03/04/11

Occupational medicine initial medical progress notes dated 10/03/08

Medical progress note dated 10/10/08, 11/05/08, 11/04/08, 11/14/08, 11/19/08

Office visit note dated 11/24/08, 12/15/08, 01/05/09, 03/10/09, 04/01/11

MRI right shoulder dated 12/08/08

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell on an apple peel and injured her right arm and leg. MRI of the right shoulder dated 12/08/08 revealed very small anterior subacromial spur with small subacromial subdeltoid bursitis and tendinosis of the supraspinatus and subscapularis tendons; there is no full thickness rotator cuff tear. There is mild to moderate glenohumeral joint osteoarthritis, best appreciated at the humeral head, with prominent ring osteophytes. There is mild tenosynovitis and interstitial tear of the long head of the biceps tendon. The patient underwent right shoulder subacromial injection on 12/15/08, which helped for 3 days. Functional capacity evaluation dated 09/22/10 indicates that the patient failed 7/7 validity criteria. It is apparent that the claimant gave a submaximal effort. Functional capacity evaluation dated 03/23/11 indicates that the patient is not currently working. Treatment to

date is reported to include medication management, diagnostic testing, right shoulder injections. The patient was placed at MMI by a designated doctor on 09/02/10 with 7% impairment rating. Required PDL is medium to heavy. Psychological evaluation dated 03/22/11 indicates that the patient has completed a course of individual psychotherapy with minimal progress. BDI is 17 and BAI is 13. Initial request for CPMP was non-certified on 04/11/11 noting there is a lack of documentation to indicate what prior conservative therapies the patient has tried and to document the functional response of the patient. The patient is currently managing pain with 500 mg of over the counter Ibuprofen. The denial was upheld on appeal dated 04/29/11 noting that there is no indication from documentation submitted for review that the patient has had no success with previous methods of treating chronic pain and that there is an absence of other options likely to result in significant clinical improvement.

Objective documentation of the patient's current physical demand level was not provided. The patient was not noted to have significant BDI and BAI scores supporting use of a tertiary level of care at this time.

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

The reviewer finds chronic pain management program 5 x week x 2 weeks (80 hours) for the right shoulder 97799 is not medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient is currently managing pain with 500 mg of over the counter Ibuprofen. The patient's required PDL is reported as medium to heavy; however, the patient's current PDL is not documented. Given the current clinical data, 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)