

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

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

**IRO CASE #:**

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

Additional 5 Sessions (5 times a week for 1 weeks) of Chronic Pain Management Program (40 units)

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

M.D., Board Certified Physical Medicine and Rehabilitation

**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 09/15/11, 09/30/11  
Peer review dated 06/30/11, 06/23/11, 03/30/11  
Progress summary dated 09/09/11  
Request for reconsideration dated 09/23/11  
Note dated 09/12/11  
Request for medical dispute resolution dated 10/14/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was entering a when the doors closed and he sustained a shoulder and arm injury. Peer review dated 03/30/11 indicates that treatment to date includes a shoulder pulley and MRI of the shoulder. The changes noted on MRI are reported to be ordinary disease of life rotator cuff findings. Peer review dated 06/23/11 indicates that the patient has a history of prior arthroscopy to the left shoulder. The patient has completed a course of physical therapy and was approved for two weeks of work conditioning. Diagnoses are listed as cervical sprain/strain, shoulder sprain/strain and muscle spasm. There is no need for additional medical care. Progress summary dated 09/09/11 indicates that the patient has completed 15 sessions of chronic pain management program to date. Pain level has decreased from 8/10 to 3/10. BDI decreased from 22 to 20 and BAI from 40 to 39.

The request for CPMP was denied on 09/15/11 noting that the patient is already at his required PDL and has made minimal progress in the last 5 sessions of the program. There is insufficient evidence of progress or need for further CPMP. The denial was upheld on 09/30/11 noting that the patient has made very minimal progress in the program to date. The

patient decreased Beck scales by 1-2 points. A recent functional capacity evaluation has not been performed or provided. No functional deficits have been identified to warrant or support the current request for this patient at this time. There is no evidence that the patient has been weaned off medications with the program already provided.

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

The patient has completed 15 sessions of chronic pain management program to date with minimal progress. BDI decreased by 1 point and BAI decreased by 2 points. There is no updated functional capacity evaluation submitted for review documenting the patient's functional gains. The previous reviewer noted that the patient has reached his required physical demand level for return to work. Given the current clinical data, the requested Additional 5 Sessions (5 times a week for 1 weeks) of Chronic Pain Management Program (40 units) are not indicated as 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)