

# I-Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/14/2011

**IRO CASE #:**

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

97799 Chronic Pain Management Program x80 Hours

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

M.D., Board Certified Family Practice

**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**

ODG-TWC Treatment Guidelines

Utilization review determination dated 09/22/11, 10/17/11

Notice of disputed issues and refusal to pay benefits dated 12/10/10

Associate statement dated 08/11/10

WC worksheet dated 08/11/10

Initial medical narrative dated 08/12/10

Office note dated 08/26/10, 09/30/10, 10/14/10, 11/04/10, 02/02/11, 03/03/11, 04/11/11, 05/16/11

Handwritten note dated 02/16/11, 04/19/11, 05/19/11, 07/01/11, 07/15/11, 08/16/11, 09/13/11

Functional capacity evaluation dated 09/15/11

Preauthorization request dated 09/20/11

Behavioral evaluation report dated 09/15/11

Request for reconsideration dated 10/06/11

Peer review addendum dated 06/16/11

Designated doctor evaluation dated 04/28/11

Cervical spine MRI dated 02/25/11

Muscle strength testing dated 03/03/11, 04/11/11, 05/16/11

Daily treatment note dated 09/20/10, 09/24/10, 09/30/10, 10/04/10, 10/08/10, 10/11/10, 10/25/10, 11/01/10, 11/05/10, 11/08/10, 11/12/10, 11/17/10

Peer review dated 11/26/10

Lumbar spine MRI dated 10/07/10

Radiographic report dated 10/07/10

Subsequent medical narrative dated 09/27/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xxxx. He was pulling a pallet backwards when he slipped and fell on his buttocks. Treatment to date includes medication management, chiropractic/physical therapy treatment, MRI scans and x-rays. The peer

reviewer notes that there is no evidence of a radiculopathy or paralysis resultant from the work related injury. Most if not all of the MRI findings are consistent with age related degenerative joint and disc changes, diabetic arthropathy and an overweight syndrome. In reasonable medical probability, the patient sustained a grade I or possibly grade II cervical and lumbar sprain and strain. A complete recovery of the compensable injury would be expected in approximately 6-9 weeks. Designated doctor evaluation dated 04/28/11 indicates that diagnoses are lumbar strain/discopathy; cervical strain/discopathy; thoracic strain and obesity. The patient was determined not to have reached MMI with anticipated MMI date of 06/28/11.

Functional capacity evaluation dated 09/15/11 indicates that current PDL is sedentary and required PDL is heavy. Behavioral evaluation report dated 09/15/11 indicates that BDI is 28 and BAI is 23. Diagnoses are pain disorder associated with psychological factor and a general medical condition; and major depression moderate.

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

Based on the clinical information provided, the request for 97799 chronic pain management program x 80 hours is not recommended as medically necessary. The submitted records fail to establish that the patient has exhausted lower levels of care. He has been diagnosed with major depression; however, there is no indication that he has undergone a course of individual psychotherapy. Per peer review and designated doctor evaluation, the patient sustained sprain/strain injuries, which should have resolved at this point. 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 KNOWLEDGBASE

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)