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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of Chronic Pain Management

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

M.D., Board Certified Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for 80 hours of Chronic Pain Management.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 05/11/12, 06/12/12

Request for reconsideration dated 06/05/12

Preauthorization request dated 05/09/12

Functional capacity evaluation dated 04/03/12

Evaluation dated 05/04/12, 02/16/12

IME dated 04/20/11

RME dated 04/26/12

IRO narrative in support of chronic pain management program dated 07/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient reported that she had to repeatedly push motors into place and noted severe pain in the hand and shoulder on the right because of the repetitive force exerted. According to an IME report from 04/20/11, her treatment has included diagnostic testing, shoulder arthroscopy in September 2000, physical therapy, group therapy and medication management. Diagnoses are resolved rotator cuff tear, right shoulder, unilateral; chronic capsulitis, right shoulder, of long-standing; and tertiary diagnosis of chronic degenerative changes, right shoulder. Ongoing chiropractic care is not reasonable or necessary. Continued treatment would not resolve the issues relative to range of motion and strength deficits of the right shoulder. Evaluation dated 02/16/12 indicates that the patient participated in several sessions of individual psychotherapy. Evaluation dated 05/04/12 indicates that BDI decreased from 34 to 30 and BAI from 27 to 23. Functional

capacity evaluation dated 04/03/12 indicates that required PDL is heavy. RME dated 04/26/12 indicates that the patient quit working in August after the injury. She did try working for a short period of time, but could not work. She has also tried other jobs, but cannot work because her shoulder and arm pain. She is not working at the present time. Current medications include Tramadol, muscle relaxant and antidepressant. A for 80 hours of chronic pain management was denied 05/11/12 noting that the length of time the claimant is removed from the date of injury would be considered to be a poor prognostic factor with respect to consideration of treatment in the form of a comprehensive pain management program. The records available indicate that past treatment may well have included treatment in the form of a comprehensive pain management program. A Peer review rebuttal dated 06/05/12 indicates that in the doctor's experience, treating patients with older injuries, such as this case, can be very, very rewarding.

The primary limiting factor in the patient's case is her pain perception and fear avoidance beliefs. The denial was upheld on appeal dated 06/12/12 noting that there is no compelling rationale how additional supervised therapy at this time would have any greater impact than previous attempts. The claimant appears motivated and has been instructed in a self-directed home exercise program. There are no red flags that substantiate medical necessity of a chronic pain management program. An appeal letter dated 07/11/12 indicates that the patient denies ever having completed a chronic pain management program at any time since her date of injury.

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

As noted by the previous reviewer, the length of time the claimant is removed from the date of injury would be considered to be a poor prognostic factor with respect to consideration of treatment in the form of a comprehensive pain management program. IME dated 04/20/11 states that continued treatment would not resolve the issues relative to range of motion and strength deficits of the right shoulder. RME dated 04/26/12 reports that there would be no further treatment that would be reasonable or necessary as related to shoulder impingement. The patient's condition is stable and will not likely change. In all medical probability, the prognosis for any change in her condition is very poor and very unlikely. The requested service is not consistent with ODG recommendations. It is the opinion of the reviewer that medical necessity does not exist for 80 hours of Chronic Pain Management.

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)