

# Prime 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/24/2012

**IRO CASE #:**

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

Pain management 5 times a week x2 weeks, neck and right shoulder, 80 hours

**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, Pain Chapter

12/02/11, 12/15/11

Handwritten note dated 11/22/11, 10/25/11, 12/22/11, 09/22/11, 11/21/11, 09/19/11, 10/10/11

Operative report dated 09/06/11

Laboratory report dated 07/27/11, 06/13/11, 03/16/11, 08/27/11

ED summary dated 08/27/11

ED physician record dated 08/14/10

Office visit note dated 10/10/11

CT head dated 08/14/10

EMG/NCV dated 11/10/10

Consultation dated 10/18/11

Functional capacity evaluation dated 11/02/11

Radiographic report dated 08/14/10

CT abdomen dated 08/27/11

Psychological evaluation dated 11/02/11

MRI cervical spine dated 09/10/10

Procedure report dated 11/09/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female who was injured when she slipped and fell on a wet kitchen floor. She had right shoulder arthroscopy with subacromial decompression, bursectomy, repair of SLAP tear She has had physical therapy, psychological counseling, medication management and lumbar epidural steroid injection on 11/09/11. Psychological evaluation dated 11/02/11 indicates that diagnoses are pain disorder associated with work related injury, depressive disorder, NOS, with major depressive features associated with work related injury, and anxiety disorder, NOS, related to injury medical condition. BDI is 32 and BAI is 38.

Functional capacity evaluation dated 11/02/11 states that required PDL is medium and current PDL is sedentary. Current medications include Hydrocodone, Amitriptyline and Fioricet.

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

The records submitted for this review do not establish that this patient has exhausted lower levels of care and is an appropriate candidate for a chronic pain program. This patient presents with severe depression and anxiety, per Beck Inventories, during the psychological evaluation performed on 11/02/11; however, there is no indication that she has undergone a recent course of individual psychotherapy or been placed on antidepressant medication. The reviewer finds there is not a medical necessity for Pain management 5 times a week x2 weeks, neck and right shoulder, 80 hours

**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)