

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

chronic pain management times 10 sessions

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

M.D., Board Certified Anesthesiology; Board Certified 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

Follow-up review of worker's compensation claim dated 05/20/11

Functional capacity evaluation intake dated 10/06/11

Request for service dated 11/23/11

Case report dated 12/13/11

Denial determination notice 12/14/11

Request for reconsideration dated 12/15/11

Case report dated 12/21/11

Denial determination notice dated 12/27/11

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, injuring her left knee, right elbow and wrist. Peer review dated 05/20/11 indicates that a designated doctor as of 03/02/11 with 1% whole person impairment placed the patient at MMI. There is no established requirement for more referrals and treatment. Functional capacity evaluation dated 10/06/11 indicates that current PDL is sedentary and required PDL is light. Request for services dated 11/23/11 indicates that the patient has completed individual psychotherapy sessions with minimal progress. BDI is 25 and BAI is 30.

Initial request for chronic pain management x 10 sessions was non-certified on 12/14/11 noting that there are limited physical findings in the documentation submitted for review and relegated to the right wrist only. While the patient has some anxiety and depression, they have both improved and can be addressed outside of a chronic pain program. Likewise, any minimal deficits in her right wrist can be dealt with in outpatient occupational therapy program. The denial was upheld on appeal dated 12/27/11 noting that no physical findings, other than the results of a functional capacity evaluation were submitted for review.

She has undergone conservative treatment with physical therapy. It is not clear that she has undergone any other medical evaluation or treatment.

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

The records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for a chronic pain management program. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient has been determined to have reached maximum medical improvement by a designated doctor with 1% whole person impairment. The reviewer finds chronic pain management times 10 sessions is not 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)