

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program 5xWk x 2Wks 80hrs right shoulder

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
Request for IRO dated 02/23/12
Utilization review determination dated 02/08/12 and 02/21/12
Request for medical dispute resolution 02/27/12
Request for services 01/20/12
Functional capacity evaluation dated 01/18/12
Carrier submission 02/28/12
Clinical records Dr. 10/03/08-11/19/08
Clinical records Dr. dated 11/24/08-03/10/09
MRI right shoulder dated 12/08/08
Designated doctor evaluation dated 09/02/10
DWC form 69 dated 09/02/10
Functional capacity evaluation dated 09/22/10
Treatment records D.C.
Behavioral health interview dated 02/03/11
Clinical records Dr. dated 03/04/11 and 04/01/11
Behavioral health individual progress notes 03/04/10-03/17/10
Functional capacity evaluation dated 03/23/11
Designated doctor evaluation dated 06/08/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries to her shoulder on xx/xx/xxxx. She was employed as cashier at Lowes. She was walking between registers on her way to lunch when she slipped on an apple peel and fell on her right side. She had immediate pain to her right shoulder, bruising on her elbow and forearm. She was seen by Dr., the company doctor. She later came under the care of D.C. She has been treated with MRIs, physical therapy, chiropractic and pain injections, TENS unit, medication, and individual psychotherapy. Imaging studies indicate a very small anterior spur with small subacromial subdeltoid bursitis and tendinosis of supraspinatus and subscapularis tendons.

There was no evidence of full thickness rotator cuff tear. There was mild to moderate glenohumeral joint osteoarthritis. She later came under the care of Dr. and was treated with corticosteroid injections and physical therapy. She was first placed at clinical maximum medical improvement on 09/02/10 with a 7% whole person impairment rating. She received additional physiotherapy treatments from DC and pain management from Dr.. On physical examination dated 06/08/11 the claimant has tenderness diffusely over the right shoulder primarily in the posterior shoulder girdle along the intrascapular area and along the trapezius.

There are no trigger points or muscle spasms identified. There is normal range of motion of the cervical spine. Right shoulder range of motion is reduced with 101 degrees flexion 22 degrees extension 108 degrees abduction 18 degrees adduction 84 degrees external rotation. Supination of the right forearm was 16 degrees as opposed to 54 on the left. Pronation was 82 as compared to 88.

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

This woman sustained an injury to her shoulder and she has chronic findings of impingement. She has failed conservative management and is clinically a candidate for surgical intervention. It would appear that the claimant's treating providers have been ineffective in the management of her pain noting that there has been an increase in BDI and BAI. She has individually undergone counseling prior to this with some reported improvement in her mental and emotional status. There is no indication from the records that the claimant would progress in a chronic pain management program to the extent that she would return to work. She is already greater than 24 months post date of injury and the prognosis for improvement in a chronic pain management program after 24 months is not supported by the ODG. Based upon the totality of the clinical information it is the opinion of the reviewer that the requested Chronic pain management program 5xWk x 2Wks 80hrs right shoulder 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)