

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Dec/02/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** chronic pain management program 5x/week x 2 weeks (80 units) left wrist, elbow, shoulder and knee

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation and 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.** It is the opinion of the reviewer that the request for chronic pain management program 5x/week x 2 weeks (80 units) left wrist, elbow, shoulder and knee is not recommended as medically necessary

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 09/16/13, 10/11/13

Request for services dated 09/04/13

Functional capacity evaluation dated 09/05/13, 10/02/12

MRI left elbow dated 10/04/12

MRI left shoulder dated 11/20/12

MRI lumbar spine dated 10/02/12

Handwritten progress note dated 09/04/13

Request for reconsideration dated 10/01/13

Impairment evaluation dated 01/31/13

EMG/NCV dated 11/30/12

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The patient stepped in a puddle of water, losing her balance. As she was falling the patient struck the wall with her left shoulder, left elbow and left wrist. MRI of the lumbar spine dated 10/02/12 revealed canal and bilateral foraminal stenosis L4-5; mild bilateral foraminal stenosis left greater than right at L5-S1. MRI of the left elbow dated 10/04/12 is within normal limits. MRI of the left shoulder dated 11/20/12 revealed supraspinatus tendinopathy without tear; mild AC joint arthropathy with down-sloping acromion. EMG/NCV dated 11/30/12 revealed evidence of L5 and S1 radiculopathy on the right and left. Impairment evaluation dated 01/31/13 indicates that the patient was determined to have reached maximum medical improvement as of 01/30/13 with 10% whole person impairment. Functional capacity evaluation dated 09/05/13 indicates that current PDL is sedentary and required PDL is medium. Request for services dated 09/04/13 indicates that the patient has

completed a course of individual psychotherapy. BDI is 11 and BAI is 13.

Initial request for chronic pain management program 5 x week x 2 weeks was non-certified on 09/16/13 noting that the claimant is nearly 11 months post soft tissue injury. The claimant has already completed a work conditioning program and 6 visits of psychotherapy. The evidence based guidelines do not allow the duplication of a program for the same work injury. A recent functional assessment has not been performed or provided as required for this request with evidence of max valid effort being performed on static and dynamic lift tests. The negative predictors have not been addressed. Documentation that the claimant is willing to change has not been provided.

There is no evidence the claimant has failed all other treatment methods. The denial was upheld on appeal dated 10/11/13 noting that the patient is not taking any opioid or narcotic medications which would require titration through a CPMP; the functional capacity evaluation appears to be invalid noting that although having been through a work conditioning program and several work hardening sessions, employee's dynamic lifting ability was 0 lbs; and a request for knee MRI was approved on 09/26/13 and if knee surgery is pending, a CPMP would not be indicated at this time.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries secondary to a fall in xx/xxxx. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient has reportedly undergone work conditioning sessions and work hardening sessions; however, there are no progress notes submitted for review. The submitted functional capacity evaluation indicates that the patient is still only capable of functioning at a sedentary physical demand level with dynamic lifting ability of 0 lbs. It is unclear if the patient is pending knee surgery at this time. As such, it is the opinion of the reviewer that the request for chronic pain management program 5x/week x 2 weeks (80 units) left wrist, elbow, shoulder and knee is not recommended as 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)