

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: chronic pain management for the left shoulder - 80 hours (10 sessions)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Family Practice

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 the chronic pain management for the left shoulder - 80 hours (10 sessions) is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Surgery scheduling form dated 07/20/12
MRI of the left shoulder dated 03/28/12
Behavioral evaluation report dated 09/09/13
Clinical note dated 09/17/13
Clinical note dated 10/18/13
Clinical note dated 11/07/13
Adverse determinations dated 09/24/13 & 10/08/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left shoulder. The MRI of the left shoulder dated 03/28/12 revealed a partial thickness tear involving the fibers of the subscapularis tendon resulting in mild medial subluxation of the markedly tendinopathic complex tear of the long head of the biceps tendon. Severe degenerative changes were also noted at the acromioclavicular joint. Moderate degenerative changes were noted at the glenohumeral joint. Moderate subacromial subdeltoid bursitis was also noted. The surgery scheduling form dated 07/20/12 indicates the patient being recommended for a left shoulder impingement repair as well as a subacromial decompression and rotator cuff repair. The behavioral evaluation dated 09/09/13 indicates the patient having a BDI-2 score of 28 and a BAI score of 26 indicating moderate depression and anxiety. The clinical note dated 09/17/13 indicates the patient continuing with left shoulder pain. The patient also reported depressive symptomology. The note indicates the patient having been treated with antidepressant medications. The patient was recommended for a chronic pain management program at that time. The clinical note dated 10/18/13 indicates the patient having been treated with medications, physical therapy, and rehabilitative exercises. The patient was continuing with functional deficits and a

secondary depressive reaction. The clinical note dated 11/07/13 indicates the patient continuing with left shoulder pain. The patient was recommended for an 80 hour course of a chronic pain management program.

The utilization review dated 09/24/13 resulted in a denial for a chronic pain management program as the patient was noted to have a depressive disorder that was noted to have gone untreated. The patient was noted to have been scheduled for a surgical intervention. The results of the patient's functional capacity evaluation were not elaborated on.

The utilization review dated 10/08/13 resulted in a denial for a chronic pain management program as the patient was being recommended for a surgical intervention at the left shoulder. Issues with the patient's cardiac workup were noted. No information was submitted regarding the patient's completion of individual or group counseling to address the ongoing depressive symptomology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of left shoulder pain. Inclusion into a chronic pain management program would be indicated provided the patient meets specific criteria to include completion exhaustion of all lower levels of care, the patient is not noted to be a surgical candidate, and the results of the functional capacity evaluation indicate the likely benefit of a multi-disciplinary program. No information was submitted regarding the patient having undergone psychological treatment to address the patient's significant complaints of depressive symptoms. It is unclear if the patient has completed all surgical procedures in that the patient is noted to have significant findings revealed by imaging studies indicating the possibility of a surgical procedure. Additionally, the results of the patient's functional capacity evaluation were not provided; therefore, the patient's current physical demand level is unclear. Given these findings, this request is not indicated. As such, it is the opinion of the reviewer that the request for the chronic pain management for the left shoulder - 80 hours (10 sessions) 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)