

Applied Resolutions LLC

An Independent Review Organization

Phone Number:
(817) 405-3524

900 N Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Email: appliedresolutions@irosolutions.com

Fax Number:
(817) 385-9609

Amended Date: 09/14/2015

Case Number:

Date of Notice: 09/10/2015

Description of the service or services in dispute:
Review Outcome:

D

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Psychology

80 hours of additional FRP (Functional Restoration Program)

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

Information Provided to the IRO for Review:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

D

E

08/07/ **Patient Clinical History**
(Summary)

E

Patient is an individual. On XX/XX/XXXX, the patient underwent a physical performance evaluation noting that she had been diagnosed with stiffness of the shoulder, spasms of the muscle and sprain of the shoulder and arm with rotator cuff syndrome of the shoulder and associated symptoms and disorders. It was noted then the initial patient intake process, the patient was not working and not employed at the time of

On 07/21/15, a request for an additional 80 hours of a functional restoration program was submitted noting the patient had been approved for 120 hours and had almost completed those hours. 80 additional hours were recommended. It was noted that a pre-treatment assessment on 06/08/15 noted pain was 4, depression 2, sleep problems 4, and BDI-2 score was 14. Current analysis dated 07/14/15 noted pain was 3, depression 2, and BDI-2 score was 10. It was noted the initial BAI score of 03/10/15 was 14, and current BAI score was 12.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 07/24/15, a utilization review report noted the request for an additional 80 hours of a functional restoration program had been reviewed and denied. The Official Disability Guidelines Pain Chapter, chronic pain programs was utilized as the citing source, and it was noted that a peer review had been performed noting this patient had attended 20 full days or 160 hours of a chronic pain program and continued to take was

14. Current analysis dated 07/14/15 noted pain was 3, depression 2, and BDI-2 score was 10. It was noted the initial BAI score of 03/10/15 was 14, and current BAI score was 12. The records indicate the patient had response to the prior care. Therefore the request was non-certified. On 08/14/15, a utilization review also noted an adverse determination for the request, and cited the Official Disability Guidelines Chronic Pain Chapter as the reference. A peer-to-peer was performed, and it was noted the previous treatment had

D

The records provided for this review failed to note significant functional improvement. BDI scores and BAI scores between initiation of treatment and current date did not reflect significant change. It was noted that a pre-treatment assessment on 06/08/15 noted pain was 4, depression 2, sleep problems 4, and BDI-2 score

achieved 160 hours, and guidelines recommend treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains, and noting that total duration should generally not exceed 4 weeks, 20 full days, or 160 hours, the rationale for continued treatment has not been provided. It is the opinion of this reviewer that the request for 80 hours of additional FRP or functional restoration program is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines

- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)

A
M
E
N
D
E
D