



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO #: _____
MDR #: M2-06-1769-01
Social Security #: XXX-XX-_____
Treating Provider: David Durkop, DC
Review: Chart
State: TX
Date Completed: 8/29/06

Review Data:

- **Notification of IRO Assignment dated 8/2/06, 1 page.**
- **Receipt of Request dated 8/2/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 7/17/06, 1 page.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Letter dated 6/15/06, 6/1/06, 6 pages.**
- **Fax Cover Sheet dated 8/8/06, 1 page.**
- **Expedited Appeal Procedure Requested dated 6/8/06, 7 pages.**
- **Patient Information (date unspecified), 1 page.**
- **Pre-Authorization Form dated 5/25/06, 1 page.**
- **Letter of Medical Necessity dated 5/25/06, 2 pages.**
- **Behavioral Assessment dated 2/6/06, 5 pages.**
- **Treatment Plan (date unspecified), 14 pages.**
- **Office Visit dated 3/20/06, 2/20/06, 1/3/06, 5 pages.**
- **Therapy Visit dated 5/24/06, 5/22/06, 2/3/06, 2/1/06, 1/30/06, 5 pages.**
- **Cervical Spine MRI dated 1/30/06, 2 pages.**
- **Carriers Statement dated 8/4/06, 2 pages.**
- **Emergency Room Record dated ____, 1 page.**
- **Physician Assessment dated ____, 1 page.**
- **Nursing Report (date unspecified), 2 pages.**
- **Emergency Physician Record dated ____, 2 pages.**
- **Operative Report dated 3/20/06, 2 pages.**
- **Report of Medical Evaluation dated 7/5/06, 1 page.**
- **Designated Doctor Evaluation dated 7/5/06, 7 pages.**
- **Examination dated 5/24/06, 3 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for chronic pain management, 10 sessions.

Determination: UPHELD - the previously denied request for chronic pain management, 10 sessions.

Rationale:

Patient's age: 61 years

Gender: Male

Date of Injury: ---

Mechanism of Injury: Fell through a rooftop, hitting a rafter with his head, then hit a tin roof, landing on the ground.

Diagnoses: Post surgical repair of complete torn left rotator cuff on 3/20/06, with arthroscopic assistance and open repair, as well as subacromial decompression.

The claimant has had conservative treatments of physical therapy, medications, chiropractic treatments and then surgical intervention for the left shoulder, as well as post surgical rehabilitation and individual psychotherapy sessions. The Texas Mutual letter, dated 6/1/06, indicated that the claimant has had prior individual psychological counseling of at least 8-10 sessions. This letter also indicated that the psychiatric reviewer, Andrew Brylowksik, M.D., felt that the claimant had plateaued with his psychological progress. He also felt that the documentation received for the requested pain management program failed to meet the criteria expected for a pain management program, specifically, with regard to appropriate patient assessments. He felt that according to the *Official Disability Guidelines*, the following criteria are necessary for the use of multidisciplinary pain management programs:

- 1) The patient's chronic pain is attributable to a physical cause.
- 2) Previous methods of treating the chronic pain have been unsuccessful and a multidisciplinary program would likely be beneficial.
- 3) The patient has a significant loss of ability to function independently, resulting from the chronic pain.

In Dr. Brylowksik's opinion, the patient did not meet criteria #2 or #3.

Reference was made to another letter from Texas Mutual, on 6/15/06, indicating that the patient had a Functional Capacity Evaluation (FCE) (no date provided), which indicated that he was functioning at light-medium duty category and that he had achieved a heavy cardiovascular level. His chiropractor, Dr. Durkop, D.C., felt that the patient could return to work after a pain management program. The actual appeal letter, dated 6/8/06, from Pinnacle Pain Management Solutions indicated that the claimant had chronic pain, pain focused behaviors, anxiety, depression, and that he should be weaned off of pain medication. He referenced medical necessity under section 408.021 "Entitlements to Medical Benefits."

An MRI of the cervical spine, dated 1/30/06, revealed a large disc protrusion with an osteophytic ridge, compressing the cervical cord at C4-5 on the right side, as well as advanced hypertrophic spondylosis involving C3-4 through C6-7, with severe canal and neuroforaminal stenosis and marked compression of the cervical cord at C4-5 and C5-6.

An MRI of the left shoulder, performed on 2/6/06, revealed a full thickness tear involving the supraspinatus tendon and early signs of arthritis. The patient underwent surgical intervention on 3/20/06, by Lubor Jarolimek, M.D. for repair of the complete torn rotator cuff with arthroscopic assistance and open repair, as well as a subacromial decompression. There was an impairment rating provided on 5/24/06, by an unknown source, which gave a final 17% whole person impairment. Other documentation actually indicated that he was evaluated by a designated doctor Harry L. Moskowitz, D.O., on 7/5/06, who found the patient to be at maximum medical improvement (MMI) with only 3% whole person impairment. This same report from Texas Mutual indicated that his shoulder surgeon, Dr. Jarolimek, found on 7/26/06 that he should participate in a work hardening program.

The actual report from Dr. Jarolimek, on 7/26/06, indicated that the patient had an open surgery to the left shoulder, with complete repair of the rotator cuff and that he kept the claimant in a sling for one month. He disagreed with the designated doctor, stating that this claimant was at maximum medical improvement (MMI) at that point, at 3 months post surgery. He stated that the claimant was in dire need of additional "supervised rehab program" prior to returning him to unrestricted duties. He also documented that the patient was not doing any physical therapy and was not doing any home exercises, at four months post surgery. He had only completed 6-7 weeks of postoperative physical therapy. Objective findings of the left shoulder revealed that strength was 5-/5, abduction was limited to 140 degrees and forward elevation was to 160 degrees. There were no reported issues of dependency on pain medication, anxiety or depression noted in this report.

The current request is to determine the medical necessity for the previously denied 10 sessions of chronic pain management program. The medical necessity for this request is not found. On 7/26/06, Dr. Jarolimek indicated that the claimant should be having a "supervised rehab program" prior to returning him to unrestricted duties; not a chronic pain management program. The patient has additionally completed 8-10 sessions of individual psychotherapy, which would indicate an attempt had been made to address his psychological status. It was the opinion of the psychiatric reviewer that "the patient's pain level of functioning, both psychologically and physically, does not support the need for the intervention at this time. The patient had plateaued with his psychological progress. This reviewer found the objective findings do not indicate a level of severity to support the need for a chronic pain program. The individualized treatment program is a generic template, and is nonspecific for this patient." Additionally, this patient has been determined to be at MMI by a designated doctor on 7/5/06, with a 3% impairment. Based upon all of the foregoing, the previous denial for a pain management program must be upheld.

Criteria/Guidelines utilized: TDI/DWC Rules and Regulations.

The ACOEM Guidelines, 2nd Edition, Chapter 6.

Official Disability Guidelines, 11th Edition, 2006.

Physician Reviewers Specialty: Chiropractor

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Physician Reviewers Qualifications: Texas Licensed DC, BSRT, FIAMA Chiropractor and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, requestor, claimant and the Division via facsimile or U.S.

Postal Service from the office of the IRO on this day of August 29, 2006.

Signature of IRO Employee:

Printed Name of IRO Employee

Lee-Anne Strang

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