

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/12/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of a chronic pain management program

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Management

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with dated 07/24/06
An operative report from dated 09/01/06
Evaluations with dated 11/08/06 and 12/12/06

A mental health evaluation with dated 12/20/06
An impairment rating evaluation with dated 12/21/06
A preauthorization request from dated 12/26/06
A letter of adverse determination from dated 01/02/07
A request for reconsideration letter from dated 01/09/07
A letter of non-authorization from at dated 01/18/07
A letter written by dated 01/29/07
A letter of dispute issue from at dated 01/31/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 07/24/06, recommended an extensor tendon repair of the right ring finger and mallet reconstruction. That surgery was performed by on 09/01/06. On 11/08/06, recommended physical therapy, Ultracet, and Celebrex. On 12/12/06, recommended Celebrex, Cymbalta, and Darvocet. On 12/20/06, recommended a pain management program. On 12/21/06, felt the patient was not at Maximum Medical Improvement (MMI) and recommended continued therapy. On 12/26/06, wrote a preauthorization request for the pain management program. On 01/02/07, wrote a letter of adverse determination for the pain management program. On 01/09/07, wrote a request for reconsideration of the pain management program. On 01/18/07, wrote a letter of non-authorization for the pain management program. On 01/31/07, wrote a letter indicating the carrier maintained its position on non-authorization.

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

This patient has not exhausted all appropriate lesser levels of medical treatment and evaluation. There is no documentation that the patient has been back to see to analyze whether there is a physiologic abnormality of the surgical site, which could explain the patient's ongoing pain. Despite statement, there is, in fact, no evidence that the patient has had any lesser levels of psychological treatment, including individual psychotherapy. Although he is taking Cymbalta, the dose of 30 mg. is not adequate enough to

state that this has been a maximized effort with the use of medical anti-depressants. Additionally, according to the the patient was still undergoing primary levels of physical therapy at the time of his evaluation, clearly indicating to me that lesser levels of medical treatment have clearly not been exhausted. Therefore, for all the reasons above, the request for 20 sessions of a chronic pain management program is not medically reasonable or necessary as related to the work related injury of, as the patient has, quite simply, not exhausted all appropriate medical treatment and evaluation options.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE**
- 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)**