



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/29/07

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Ten sessions of a chronic behavioral pain management program

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Hand Surgery

### **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 Employer's First Report of Injury or Illness form dated xx/xx/xx  
Emergency room reports from D.O. dated xx/xx/xx and 03/06/07  
X-rays of the right wrist interpreted by M.D. dated xx/xx/xx  
DWC-73 forms from M.D. dated 09/19/06, 09/27/06, 10/13/06, 11/20/06, 12/26/06, 01/29/07, 03/02/07, 03/08/07, 03/15/07, 04/12/07, 04/27/07, and 05/14/07  
Evaluations with R.N. dated 09/19/06 and 10/06/06  
Evaluations with Dr. dated 09/19/06, 09/22/06, 09/28/06, 11/20/06, 01/09/07, 02/12/07, 03/02/07, 03/08/07, 03/15/07, 04/03/07, 04/12/07, 04/27/07, and 05/01/07  
An MRI of the upper extremity interpreted by Dr. (no credentials were listed) dated 10/02/06  
Evaluations with M.D. dated 10/11/06, 10/30/06, 11/10/06, 02/08/07, and 03/15/07  
DWC-73 forms from Dr. dated 10/11/06, 10/30/06, 11/10/06, and 02/08/07  
An evaluation with O.T., C.H.T. dated 10/13/06  
Notices of Disputed Issue(s) and Refusal To Pay Benefits form from the insurance carrier dated 11/07/06, 03/09/07, and 04/05/07  
A patient information sheet from an unknown provider (the signature was illegible) dated 11/28/06  
An evaluation with M.D. dated 11/29/06  
An EMG/NCV study interpreted by M.D. dated 01/22/07  
A visit note with an unknown nurse (the signature was illegible) dated 01/28/07  
Emergency room reports from M.D. dated 03/01/07 and 03/06/07  
Laboratory studies dated 03/01/07  
An evaluation with L.P.C. dated 04/04/07  
Medication lists dated 04/11/07 and 06/05/07  
A letter of adverse determination from Ph.D. at Direct dated 04/18/07  
A peer review summary from M.D. dated 04/19/07  
A letter of adverse determination from M.D. at Direct dated 05/01/07  
An IRO summary from an unknown provider (no name or signature was available) dated 06/01/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

Dr. diagnosed a right wrist/thumb sprain and tendonitis and prescribed Anaprox. X-rays of the right wrist interpreted by Dr. were unremarkable. On 09/22/06, Dr. performed a Morphine injection and recommended a volar splint, continued arm sling, Naprosyn, and Lortab. An MRI of the wrist interpreted by Dr. on 10/02/06 revealed a somewhat limited examination due to motion artifact. On 10/11/06, Dr. performed a Cortisone injection to the wrist and prescribed Naprosyn. On 10/30/06, Dr. performed another Cortisone injection and continued her in the splint and in therapy. The insurance carrier provided a Notice of Disputed Issue regarding de Quervain's syndrome on 11/07/06. On 11/10/06, Dr.

recommended surgery. On 11/29/06, Dr. also requested surgery. On 01/09/07, Dr. recommended an EMG/NCV study and continued splinting and medications. An EMG/NCV study interpreted by Dr. on 01/22/07 revealed mild to moderate right carpal tunnel syndrome. On 03/01/07, Dr. noted probable reflex sympathetic dystrophy (RSD). On 03/02/07, Dr. recommended a splint, Hydrocodone, Flexeril, Naprosyn, and injections of Demerol and Phenergan. On 03/09/07 and 04/05/07, the insurance carrier disputed TIBS. On 03/15/07, Dr. requested an MRI of the right wrist and continued medications. On 04/04/07, Ms. requested a chronic pain management program. On 04/18/07, Dr. wrote a letter of adverse determination for the pain management program. On 05/01/07, Dr. also wrote a letter of adverse determination for the pain management program.

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

This patient had a number of diagnoses in regard to her upper extremity. Those include carpal tunnel syndrome, tendonitis, and tenosynovitis. In my experience as a fellowship trained hand surgeon, chronic pain management is not necessary for those diagnoses or any diagnosis of the upper extremity unless something like reflex sympathetic dystrophy (RSD) is involved. Specifically, the ODG Guidelines in the treatment of the above stated disorders never mention anything about chronic pain management. Thus, in my opinion, the requested 10 sessions of chronic pain management is outside of the normal scope of treatment for those above stated diagnosis and would not be necessary.

**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)