CompPartners

Notice of Independent Review Decision

DATE OF REVIEW: 6/29/07

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVIDES IN DISPUTE

Determine the appropriateness of the previously denied request for 30 sessions of chronic pain management program.

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

Texas licensed MD in Pain Management and is currently listed on the TDI/DWC ADL list.

REVIEW OUTCOME

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

X Upheld (Agree)

□ Overturned (Disagree)

□ Partially Overturned (Agree in part/Disagree in part)

The previously denied request for 30 sessions of chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Fax Cover Sheets dated 6/20/07, 2 pages.**
- **Notice to CompPartners, Inc. of Case Assignment dated 6/20/07, 2 pages.**
- **Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 6/20/07, 1 page.**

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/18/07, 1 page.**
- **Texas Department of Insurance - IRO Request Form dated 6/18/07, 3 pages.**
- **Request Form Request for a Review by an Independent Review Organization dated 6/15/07, 3 pages.**
- **Determination Notification Letters dated 6/7/07, 5/24/07, 4 pages.**
- **Request for a Chronic Pain Management Program dated 5/27/07, 5/25/07, 2 pages.**
- **Fax Cover Sheet/Authorization Request dated 5/25/07.**
- **Request for Reconsideration dated 5/25/07, 2 pages.**
- **Initial Interview/Assessment/Treatment Plan Report dated 3/23/07, 10 pages.**
- **Chronic Pain Management Program Authorization Request (unspecified date), 1 page.**
- **Problem Focused History/Historical Note dated 3/19/07, 1/17/07, 12/19/06, 10/16/06, 5 pages.**
- **Examination Note dated 3/19/07, 2 pages.**
- **Diagnosis Sheet dated 3/19/07, 1 page.**
- **Range of Motion Measurements dated 3/19/07, 1 page.**
- **Treatment Plan dated 3/19/07, 1/17/07, 12/19/07, 8/14/06, 4 pages.**
- **Progress Report dated 5/18/07, 1 page.**

PATIENT CLINICAL HISTORY [SUMMARY]:
Age:
Gender: Female
Date of Injury:
Mechanism of Injury: Repetitive strain.

Diagnosis: Carpal tunnel syndrome and shoulder problems.

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

From the information provided, it appears that this female had a work-related injury involving the wrists and upper extremities bilaterally, secondary to a repetitive strain injury. The patient reportedly was with the diagnoses of carpal tunnel syndrome and shoulder problems. Subsequent to the injury, reportedly the patient completed conservative treatment. In addition, reportedly, the insurance company denied medications, so the patient was only taking over-the-counter Tylenol. Of note, there were no radiographic and/or diagnostic studies submitted with this review. Furthermore, it is not known whether this patient has exhausted all interventional and surgical procedures for her problem. Based on the documentation provided, objective and subjective findings, this request is not reasonable or necessary. With respect to the criteria for predicted success from a chronic pain management program, it appears that several criteria would argue against the patient benefiting from such a program. For one, the patient demonstrated severe to extreme depression and anxiety, which have not had any type of preliminary treatment. Moreover, repeated goals relating to pain management or “coping” would be difficult to achieve without adequate control of psychological confounding

factors. This focus is specifically proscribed in this type of patient because such strategy "may reinforce psychological, environmental, and psychosocial factors that promote chronic pain states." This patient had negative predictors for outcome from a chronic pain management program to include a negative outlook about future employment, high levels of psychosocial distress, the duration of pre-referral disability time and pre-treatment levels of pain. Finally, according to the Official Disability Guidelines, chronic pain management program treatment has not been suggested for longer than two weeks at a time. The efficacy is documented by subjective and objective gains.

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 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
ODG Treatment Index 5th Edition, 2006/2007 Pain Section-Chronic Pain Programs.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHRIOPRACTIC 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).

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.