

RYCO MedReview

DATE OF REVIEW: 06/19/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program five times a week for six weeks for a total of 30 sessions

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

Board Certified in Orthopedic 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

A CT scan of the distal radioulnar joints interpreted by M.D.
Laboratory studies dated 03/28/06
Hand and upper extremity evaluations with M.D. dated 05/31/06 and 07/25/06
A hand therapy evaluation with O.T.R., C.H.T. dated 06/01/06
A statement of necessity from Dr. dated 06/02/06
Hand therapy progress reports from Ms. dated 06/26/06 and 07/08/06
Evaluations with Dr. dated 06/27/06, 07/25/06, 08/28/06, 09/25/06, and 12/05/06

An information form from the patient dated 09/11/06
Evaluations with M.D. dated 09/12/06, 10/13/06, 11/17/06, and 01/18/07
A letter of medical necessity from Dr. dated 10/16/06
A mental health evaluation with M.S., L.P.C.-I. and M.A., L.P.C. dated 01/04/07
An evaluation with N.P. for Dr. dated 01/18/07
A psychological evaluation with Ph.D. dated 03/15/07
A behavioral assessment with M.A., L.P.C.-I. and Mr. dated 04/04/07
Requests for a chronic pain management program dated 04/30/07 and 05/03/07
A letter of non-authorization from Ph.D. at Services dated 05/02/07
A request for reconsideration letter from D.C. dated 05/03/07
A letter of non-certification from Ph.D. at SRS dated 05/10/07
A request for an MDR from Dr. dated 05/31/07

PATIENT CLINICAL HISTORY [SUMMARY]:

A CT scan of the distal radioulnar joints interpreted by Dr. was unremarkable. On 06/01/06, Ms. recommended therapy three times a week for eight weeks. On 06/27/06, Dr. continued the patient on Neurontin and physical therapy. On 07/25/06, Dr. referred the patient to pain management. On 09/12/06, Dr. prescribed Naprosyn and Ultram and recommended continued Neurontin and physical therapy. On 10/16/06, Dr. wrote a letter of medical necessity for psychotherapeutic intervention and a pain management program. On 11/17/06, Dr. increased Neurontin. On 01/04/07, Ms. and Mr. recommended five individual therapy sessions. On 03/15/07, Dr. also recommended individual therapy. On 04/04/07, Ms. and Mr. recommended a pain management program. On 05/02/07, Dr. wrote a letter of non-authorization for the pain management program. On 05/10/07, Dr. also wrote a letter of non-authorization for the pain management program.

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

In my opinion, the request for chronic pain management would not be reasonable or necessary. A lot of the studies being quoted to support the use chronic pain management do not necessarily say chronic pain management; they are talking about multidisciplinary approaches. This could mean a number of different things. The patient has had therapy and has had a number of treatments that have failed. I do not see where chronic pain management would be anything above and beyond what the patient has already had. The chronic pain management would likely not change the patient's symptomatology. Official Disability Guidelines does say that a multidisciplinary approach is best for chronic wrist pain. Typical treatment for this type of complaint is a combination of medications, activity modification, and therapy that the patient has already had and has not responded to.

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
- 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)