



# PROFESSIONAL ASSOCIATES

**DATE OF REVIEW:** 05/29/07

**IRO CASE #:**

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

Chronic pain management program for 20 sessions over four weeks (97799)

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

Licensed in Psychology

**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 D.O. on 02/06/07  
MRI of the right wrist interpreted by M.D. dated 02/27/06  
Bilateral upper extremity EMG/NCV study dated 05/19/06 and interpreted by M.D.

An operative report dated 08/10/06 from M.D.  
An EMG/NCV study of the bilateral upper extremities dated 12/15/06 and interpreted by an unknown provider at Med (no name or signature was available)  
A preauthorization review summary dated 01/18/07 from Associates  
An MRI of the right wrist dated 02/05/07 and interpreted by M.D.  
An evaluation with M.D. dated 01/29/07  
Evaluations with M.D. on 02/12/07, 03/12/07, and 04/09/07  
A behavioral health reevaluation dated 02/27/07 with M.A., L.P.C.  
An addendum from M.A., L.P.C. dated 02/27/07  
Evaluations M.D. dated 03/05/07, 03/15/07, and 04/19/07  
A Functional Capacity Evaluation dated 03/13/07 from an unknown physical therapist (the signature was illegible)  
A preauthorization request for a chronic pain management program dated 03/27/07 from M.A., L.P.C.  
A preauthorization determination dated 03/27/07 from Associates  
A neurological consultation with M.D. dated 04/10/07  
A reconsideration request for a chronic pain management program dated 04/19/07 from M.A., L.P.C.  
Another adverse determination preauthorization notice dated 04/19/07 from Associates.  
A request for an MDR/IRO process dated 05/01/07 from M.A., L.P.C.

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

An MRI dated 02/27/06 revealed fluid within the distal radial ulnar joint as well as high signal findings associated with distal ulna suggesting posttraumatic arthroplasty at the distal ulna and a possible ulna styloid fracture. There was also evidence for arthropathic type changes at the upper articular portion of the distal radius and within the carpal bones of the first and second carpal row without evidence for avascular necrosis. An EMG/NCV study dated 05/19/06 suggested a C8 or T1 radiculopathy on the right as well as a C6 radiculopathy on the right with the possibility of spinal stenosis with multiple nerve root impingements. The patient underwent a right wrist arthroscopy with exploration, debridement, and partial synovectomy and an arthroscopic repair of the triangular fibrocartilage complex (TFCC) of the right wrist on 08/10/06. An additional EMG/NCV study on 12/15/06 suggested right ulnar neuropathy at the elbow. An MRI dated 02/05/07 revealed ECU tendinosis at the level of the ulnar styloid and a mild increased signal but no abnormal enhancement of the median nerve to indicate carpal tunnel syndrome. Dr. scheduled the patient for a repeat MRI and performed a Kenalog and Marcaine injection on 01/29/07. On 02/27/07, Ms. recommended an interdisciplinary treatment program for a minimum of six weeks. On 03/05/07, the patient had told M.D. for months and months that his symptoms and depression were probably controlled on Zoloft 100 mg., which was switched to Paxil 20 mg. A Functional Capacity Evaluation (FCE) dated 03/13/07 indicated the patient did not meet his job requirements and he was functioning in the light physical demand level. Ms. again requested a chronic

pain management program on 03/27/07. Associates provided a denial of the chronic pain management program for four weeks on 03/30/07. Ms. provided a reconsideration request for the chronic pain management program on 04/19/07. On 04/26/07, Associates again denied the request for the chronic pain program. Ms. filed a request for an MDR/IRO on 05/01/07.

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

Based on the records and the medical and psychological evidence provided, a chronic pain management program is not reasonable or necessary as cited in the (ODG) Official Disability Guidelines below. The ODG provides research and recommendations for a chronic pain program for the low back pain only. Of the lack of research concerning success of treatment in the chronic pain management program for an upper extremity injury does not rule out this treatment. The ODG criteria must clearly be met as listed below. Also, in my opinion, the treatment request is excessive. There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain as opposed to low back pain and generalized pain symptoms. (Karjalainen, 2003)

Per the ODG, "Treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains". Criteria for the general use of multidisciplinary pain management programs are:

1. An adequate and thorough evaluation has been made.
2. Previous methods of treating the chronic pain have been unsuccessful.
3. Patient has a significant loss of ability to function independently resulting from the chronic pain.
4. The patient is not a candidate for surgery would clearly be warranted.
5. The patient exhibits motivation to change and is willing to forego secondary gains including disability payments to effect this change.

In this case, previous methods of treatment have been at least partially successful and new medications have recently been prescribed. Dr. documented on 03/15/07 that he had prescribed Paxil which had helped the patient. Dr. documents "his emotional state he claims now is getting under control". Dr. also documents that the patient is starting a trial of Lyrica. The request for a pain program was made on 03/27/07 prior to Dr. having the opportunity to evaluate the effectiveness of this new medication. The mental health worker who requested the pain program documented that the patient "did not respond to primary or secondary stages of outpatient physical therapy and/or mental/emotional treatment in a reasonable period of time". This information is

contradictory to Dr.'s documentation. There was no documentation provided concerning the six psychotherapy sessions to demonstrate success or failure.

Documentation by Dr. on 04/10/07 rules out chronic regional pain syndrome and a diagnosis of right ulnar neuropathy at the elbow. This condition was not part of the patient's injury claim and may require surgical intervention. Until this issue is resolved, the patient is not a candidate for a chronic pain program as listed in the ODG above.

The requesting therapist does not provide "an adequate and thorough evaluation" that addresses the psychosocial factors, as well as the appropriate literature citing establishing an adequate rationale for a ten day trial of the chronic pain program. Although her level of care has not been exhausted and surgical intervention is still possible on the elbow which would certainly impact the work related upper extremity injury. Also, there was a lack of documentation demonstrating that previous methods of treatment of treating the chronic pain have been unsuccessful.

**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)**