

RYCO MedReview

DATE OF REVIEW: 05/31/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten days/sessions of chronic pain management (97799-CP)

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

Licensed by the Texas State

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

Evaluations with M.D. dated xx/xx/xx and 12/06/06
Evaluations with D.C. dated 02/15/06 and 02/22/06
An MRI of the left knee interpreted by M.D. dated 02/24/06
A behavioral medicine evaluation with M.A., L.P.C.-I and M.S., L.P.C. on 03/03/06
EMG/NCV studies interpreted by M.D. dated 03/07/06 and 03/14/06
Evaluations with D.O. dated 04/03/06, 01/16/07, and 02/13/07
A chronic pain management plan from P.T., M.S., L.P.C., Ph.D., and Ph.D. dated 01/16/07
A Designated Doctor Evaluation with D.O. dated 03/06/07
An EMG/NCV study interpreted by M.D. dated 03/06/07
A physical therapy evaluation with Mr. dated 03/20/07
A request letter from Mr. dated 03/29/07
Letters of denial from dated 04/05/07, 04/17/07, and 05/09/07
A reconsideration letter from Mr. dated 04/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. recommended continued treatment with Dr. and Celebrex, Elavil, and Ultram. On 02/15/06, Dr. recommended active therapy and an MRI of the left knee. An MRI of the left knee interpreted by Dr. on 02/24/06 revealed narrowing in the knee and marked thickening of the quadriceps and patellar tendon. A prior surgery was also noted. On 03/03/06, Ms. and Ms. requested six sessions of individual psychotherapy. An EMG/NCV study interpreted by Dr. on 03/07/06 was unremarkable. Another EMG/NCV study interpreted by Dr. on 03/14/06 revealed evidence consistent with entrapment and trauma in the wrists. On 04/03/06, Dr. recommended a carpal tunnel release. On xx/xx/xx, Dr. recommended a chronic pain management program. On 02/13/07, Dr. continued Naprosyn, Tramadol, and Elavil. On 03/06/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 25% whole person impairment rating. On 03/20/07, Mr. requested further therapy in the pain program. On 03/29/07, Mr. requested 10 more sessions of the pain program. Letters of denial from were provided on 04/05/07, 04/17/07, and 05/09/07.

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

Based upon the supplied documentation, the patient was placed at MMI, meaning that his condition had progressed to the maximum point expected. With 25% impairment, the patient is expected to have residual deficits with regard to his condition. Documentation does not substantiate the likelihood that such a program would move the patient more towards returning to work, which is the main consideration of this case. The patient has undergone a reasonably significant amount of chronic pain management for the nature of his condition, and we do not expect any greater functional changes with ten additional sessions. As indicated by the Designated Doctor, it appears the patient would benefit from a job retraining through.

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)