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Notice of Independent Review Decision

DATE OF REVIEW: 04/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: Ten (10) sessions of Chronic Pain Management

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

Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Hospital Records, x-rays of the left hand xx/xx/xx
2. Evaluation by Dr. xx/xx/xx, 2/23/06, 4/13/06, 6/22/06, 7/20/06, 10/4/06
3. Operative Report xx/xx/xx
4. Follow up with Dr. 1/24/06
5. Employment letter from Flexible Foam regarding employment options 2/3/06
6. Request for authorization for debridement and skin grafting (approval) 4/27/06
7. Laboratory work 5/9/06
8. Operative report 5/12/06
9. Physical therapy evaluation 6/8/06
10. Daily physical therapy log 6/06-7/06
11. Request for authorization for physical therapy (denial) 6/27/06
12. Order for Designated Doctor Evaluation 9/20/06
13. Functional Capacity Evaluation 10/10/06
14. Daily physical therapy notes (no dates)
15. Request for Required Medical Evaluation 10/30/06
16. Designated Doctor Evaluation by Dr. 10/4/06

17. Order for Required Medical Evaluation 10/30/06
18. Request for authorization for physical therapy (denial) 11/8/06
19. Request for authorization for physical therapy appeal (approval) 11/21/06
20. Therapy approval amendment 11/21/06
21. Required Medical Evaluation with Impairment/MMI evaluation with Dr. 1/16/07
22. Initial behavioral medicine evaluation 1/22/07
23. Request for Benefit Review Conference (BRC) 1/19/07
24. Request for authorization for individual psychotherapy (partial approval) 2/5/07
25. Individual psychotherapy notes dated 02/07/07, 04/12/07, 04/27/07
26. Individual psychotherapy treatment summary 3/1/07
27. Request for authorization for individual psychotherapy (approval) 3/8/07
28. Impairment rating review by Dr. 3/28/07
29. Recommendation for CPMP 5/16/07
30. Note from Dr. 5/29/07
31. Letter from employees attorney requesting medications refills 6/4/07
32. Letter from employee regarding doctor change request 6/4/07
33. Request for authorization for physical therapy (denial) 6/26/07
34. Requested durable medical equipment information dated 10/08/07
35. Miscellaneous notes from follow up from 7/07 to 12/07
36. Peer review by Dr. 2/28/08
37. Behavioral medicine evaluation 3/5/08
38. Evaluation by Dr. with Functional Capacity Evaluation 3/18/08
39. Request for initial ten days in a CPMP 3/24/08
40. Initial preauthorization review (denial) by Dr. 3/27/08
41. Rebuttal letter from Dr. 3/27/08
42. Request for reconsideration 4/3/08
43. Appeal preauthorization review (denial) by Dr. dated 04/09/08
44. Rebuttal letter from Dr. 4/9/08
45. Also included were numerous work status reports, impairment rating dispute documents and other various miscellaneous information.
46. **Official Disability Guidelines.**

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a xx year old male who sustained an injury to the left hand on xx/xx/xx. The employee worked as a machinist. He reported on the day of the injury, the machine he was working on had a "saw" malfunction that came down onto his fingers. He suffered lacerations with partial amputation to the index and middle fingers and a small laceration to the ring finger. When x-rays were completed, it was determined he also had a transverse distal phalangeal fracture at the base of the middle finger. The employee was provided antibiotics and a tetanus shot. Upon further evaluation, it was determined that the fracture was not stable, and there was some ulnar deviation.

On xx/xx/xx, the employee was taken to surgery and underwent debridement of the wound site and open reduction and internal fixation with K-wire.

The employee was seen for follow up on 01/24/06 and reported an incident where his hand had been stepped on. On evaluation, everything was noted to be ok. The employee also reported he could not return to work as light duty was not available.

On 02/03/06, from xxxx submitted a letter and indicated there were several positions available for the employee to return to at light duty.

When seen for follow up on 02/23/06 for pin removal, the employee indicated he was back at work but not with restrictions. He indicated they placed him back at his "regular job". Subsequently the employee developed an infection and was experiencing other complications.

On 05/12/06, the employee required debridement of the index finger due to necrosis. However, there was no "meat" for a skin graft. Subsequently, the employee was evaluated for and began physical therapy. The employee continued to progress and continued with work restrictions.

In July, 2006, the employee was placed at Maximum Medical Improvement (MMI) and given 8% impairment.

On 10/04/06, the employee was seen for Designated Doctor Evaluation. He was placed at a MMI status as of 10/06 and determined to have a 20% hand impairment and an 18% upper extremity impairment resulting in a 22% whole personal impairment. An FCE was also completed and revealed the employee to be at a below sedentary physical demand level. Effort was noted to be consistent. Of note, the employee also indicated at that time he was not taking any medications. He was recommended for and continued in physical therapy.

On 01/16/07, the employee was seen for a Required Medical Examination (RME) as the original impairment was being disputed. The reviewer concurred with the original MMI date but determined a 14% whole personal impairment. Impairment was again disputed; however, the reviewer did not change his determination. Subsequently on 01/22/07, an initial behavioral medicine evaluation was completed. At that time, the employee reported taking one Hydrocodone nightly due to intense and intermittently unbearable pain. He reported significant lifestyle changes and changes in his psychological status as a result of his injury. Complaints included loss of function, sleep disruption, increasing alcohol use, increasing stress, financial strain, irritability, tension, nervousness, sadness, and depression. Beck Depression and Anxiety Inventories were completed; and scores were 16 and 18 respectively. The diagnostic impression was posttraumatic stress disorder secondary to work injury and major depressive disorder. The employee was recommended for participation in individual psychotherapy. Progress notes indicate the employee participated in the sessions but was moderately anxious and depressed. He also reported he was

working full-time without restrictions, as his employer would not accommodate the restrictions.

On 03/01/07, the employee was seen for a reassessment after having completed individual psychotherapy. He indicated he had been terminated from his position. He also reported significant stress, lack of understanding of his diagnosis, and the reason for his termination. The employee was recommended for continuation in individual psychotherapy.

On 03/28/07, Dr. performed an impairment rating review. He noted the impairment was incorrect but also suggested the variances were due to questionable cooperation on the part of the employee. It was opined that a reexamination by an un-interested third party would be appropriate.

In May, 2007 after continuation in individual psychotherapy, the employee was again reassessed and recommended for participation in group therapy and a possible return to work program. Subsequently, continued physical therapy was denied; however, the employee was still seen for follow up.

In February, 2008, Dr. performed a peer review of records on the employee. Dr. opined the employee had exhausted physical therapy as per evidenced-based guidelines, and he recommended continued follow up, use of a home exercise program, and determined continued medications were also necessary.

On 03/05/08, a repeat behavioral medicine evaluation was performed. Findings were essentially the same as the initial review. However, Beck scores had increased significantly. Beck Depression Inventory was now at 56 and Beck Anxiety Inventory was 31. The diagnostic impression now also included pain disorder. The employee was recommended for participation in multidisciplinary care. An FCE was also completed; and the employee was noted to be at a medium physical demand level, which was a significant improvement from the prior evaluation. Again, the employee was recommended for participation in a chronic pain management program.

On 03/24/08, a request was made for ten sessions of chronic pain management.

Services were denied on 03/27/08 by Dr. indicating insufficient objective evidence of a good prognosis for improvement. Dr. also indicated the employee was working and a "return to work" program was not needed.

A letter of reconsideration was submitted indicating the employee was not in fact working.

On 04/09/08, the request for appeal was reviewed and denied by Dr.. There was some confusion during the peer discussion regarding what the request was actually for. He also opined the speaking physician did not have a clear

understanding of what was going on with the case and advised the employee be seen to rule out a remedial hand condition.

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

There were several inconsistencies in the overall clinical presentation, and as such, the medical necessity for ten sessions of chronic pain management is not established, and the denial is upheld. The employee participated in individual psychotherapy and was placed on psychotropic medications and did not make improvement.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

1. ***Official Disability Guidelines***, Return To Work Guidelines (2007 *Official Disability Guidelines*, 12th Edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp*, 5th Edition) Accessed Online