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## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/20/08

**IRO CASE #:**

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

20 sessions of chronic pain management

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

Board Certified in Physical Medicine and Rehabilitation

### **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.

20 sessions of chronic pain management - Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

MRI of the right wrist, M.D., 11/21/07

Clinical Notes, M.D., 12/10/07, 01/08/08, 02/21/08, 03/06/08, 04/01/08

Activity Restrictions, Dr. 12/10/07

Multiple x-rays of wrist, 12/10/07, 01/08/08, 02/21/08, 03/06/08

Pre-Authorization Determination Letter, 01/23/08  
Operative Report, Dr. 02/05/08  
Therapy Prescription, Dr. 04/01/08  
Nurse Case Manager's Note, 04/01/08  
Mental Health Evaluation, M.Ed., L.P.C., 04/24/08  
Pre-Authorization Request, M.D., 05/02/08  
Adverse Determination Letter (Initial Review), 05/07/08  
Peer Review of Medical Records, M.D., 05/11/08  
Request for Reconsideration, Dr. 05/14/08  
Pre-Authorization Request, Dr. 05/15/08  
Adverse Determination Letter (Reconsideration), 05/21/08  
Letter from Dr. 06/02/08  
Notice of IRO assignment, TDI, 06/02/08  
The ODG Guidelines were not provided by the carrier or the URA

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

The patient suffered injury of her right wrist. Treatment included physical therapy and rehabilitation, medications, surgical triangular fibrocartilage disc tearing repair and a mental health evaluation.

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

It appears that this patient suffered a wrist injury in mid xxxx and received conservative treatment which was comprised of physical therapy and a localized steroid injection to the right wrist, culminating in a right triangular fibrocartilage disc tearing repair surgery performed arthroscopically by M.D., on 02/05/08. Following this procedure, the patient apparently became very reluctant to perform any type of postoperative physical therapy or movement and developed chronic pain. Since it is now more than four months post surgical repair with obvious physical findings on a postoperative result, in accordance with the *ODG*, a further level of care does become apparent and indicated, which in this case, noting the psychological assessment that was performed, the program of chronic pain management with twenty sessions does appear to be medically appropriate under the circumstances. Therefore, it is appropriate to proceed with this higher level of care.

The *ODG* criteria does support progress to this level considering the significant problems noted following this injury and the treatment already rendered.

### **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)