



Notice of Independent Review Decision
PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 5/2/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program, 5 times/week for 4 weeks (20 sessions)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 2006 and pain Management since 2006.

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)

Chronic pain management program, 5 times/week for 4 weeks (20 sessions) Overturned

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a female who reportedly suffered an injury after repeated trauma to both wrists. She has undergone MRI, right carpal tunnel repair (4/25/2005), left carpal tunnel repair (7/25/2005), right shoulder arthroscopy (12/27/2006), another right carpal tunnel repair (2/8/2007), several courses of physical therapy, EMG/NCV studies, injections to the shoulder, several psychological evaluations, work hardening program, medication management, and individual psychotherapy. She continues to have complaints of pain rated 7/10 and anxiety and depression.

At this time, the request for 20 sessions of a chronic pain management program is under review for medical necessity.

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

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement;
- (2) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;
- (3) The patient has a significant loss of ability to function independently resulting from the chronic pain;
- (4) The patient is not a candidate where surgery or other treatments would clearly be warranted;
- (5) The patient exhibits motivation to

Name: Patient_Name

change, and is willing to forgo secondary gains, including disability payments to effect this change; and (6) Negative predictors of success above have been addressed.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Total treatment duration should generally not exceed 20 sessions. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved.

#1: The claimant has had a pre-program FCE on (2/18/2008).

#2/4: All previous treatments have failed to alleviate the patient's chronic pain and no future medical treatments are planned.

#3: The claimant's loss of function is well documented.

#5: The claimant expresses motivation for the program and is demonstrates no secondary gain.

#6: Negative predictors have been adequately assessed and addressed and are well documented.

The claimant has been adequately screened and meets the suggested criteria for a CPM to be considered medically necessary. Additionally there is a well defined treatment plan complete with reasonable goals and expectations for assessment during the program. A chronic pain management program is considered both reasonable and medically necessary for the claimant in accordance with the ODG guidelines. Therefore, the previous denial is overturned.

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
- X** 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)