ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 09/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.C., specializing in rehabilitation

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X___Upheld (Agree)

_____ Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

While the ODG does provide that additional sessions of chronic pain management program may be approved if and when necessary, the necessity has not been established in this case. The request for ten final sessions of chronic pain management program was made on 07/31/08. The noncertification of these additional ten sessions is upheld.

INFORMATION PROVIDED FOR REVIEW:
1. 08/15/08, referral, seventeen pages
2. 07/23/08, Peer Review for carpal tunnel syndrome, requesting ten sessions of chronic pain management therapy with zero approved by , M.D.
3. 08/06/08, Peer Review requesting ten sessions of chronic pain management program, zero certified, by , D.C.
4. 08/15/08, Notice of IRO Assignment
5. 08/20/08, Letter to IRO signed by
7. 09/18/08, letter from to the Preauthorization Department requesting chronic pain management program, ten sessions; this includes an FCE, 25 pages
8. 07/12/08, Designated Doctor Examination by , M.D., giving the patient maximum medical improvement of 07/01/08 with a 1% impairment rating, nine pages

9. 07/28/08, , M.D., DWC-73 with return to work, modified duty
10. 07/28/08, fax cover from to , DDE report
11. 08/20/08, treatment history, mostly illegible, twelve pages
12. 08/20/08, memo, claim summary and request for a new Designated Doctor, two pages
13. 08/20/08, ODG Guidelines/TWC, four pages
14. 08/15/08, letter to the IRO signed by
15. 08/15/08, assignment of IRO
16. 08/15/08, request for records
17. 08/13/08, fax receipt to the IRO processing from at extension 306, 41 pages, which includes the following:
18. 07/18/08 letter, , preauthorization request for ten days of CPMP, seven pages
19. Interdisciplinary pain treatment component and goals of treatment, chronic pain design and CPMP Day Treatment design, two pages
20. 07/22/08, environmental intervention signed by , Ph.D
21. 07/23/08, Peer Review, four pages
22. 07/31/08, fax from , Ph.D. to the preauthorization department, request for reconsideration of ten final sessions of chronic pain management program, 27 pages
23. 08/06/08, Peer Review by , D.C., four pages
24. 05/22/08, patient face sheet
25. 03/13/08, a prescription for the injured employee for CPM, thirteen pages
26. 05/06/08, history and physical for chronic pain management program by D.O., two pages
26. 06/03/08, , D.O., followup
27. 01/18/08, initial behavioral medical consultation, five pages

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The injured employee developed carpal tunnel syndrome as a result of repetitive typing injury. She was treated with numerous sessions of physical therapy and twenty sessions of chronic pain management. An additional ten sessions of chronic pain management program were requested.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
The ODG Guideline does provide for chronic pain management program for injured employees. However, the recommendation does not extend beyond twenty visits unless there is significant clinical information to support the need for an extended amount of sessions. The need for that care has not been established in this case. The patient was performing a job that required a TDL of light, and at the present time, she has achieved TDL improvement where she reached the level of being able to work at the level of a TDL of light. The patient has shown interest in vocational rehabilitation. She has no job to go back to at this time, and there has been no basis presented that proves the necessity for the additional therapy sessions in a chronic pain management program. Due to the above findings, I have recommended that the non-certification of ten additional sessions of a chronic pain management program have been upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____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.
___X _Medical judgment, 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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)