Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 03/09/09 (REVISED 03/10/09)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of a chronic pain management program

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine

REVIEW OUTCOME

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

X 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.

Ten sessions of a chronic pain management program - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form dated xx/xx/xx

An evaluation with , D.O. dated 02/21/08
A DWC-73 form from Dr. dated 02/21/08
Evaluations with , D.O. dated 02/28/08, 03/18/08, and 04/17/08
DWC-73 forms from Dr. dated 02/28/08, 03/18/08, and 04/17/08
A prescription from Dr. dated 04/17/08
Evaluations with , D.O. dated 05/05/08, 06/02/08, 07/07/08, 08/04/08, 09/02/08, 10/06/08, 11/03/08, 11/17/08, 12/02/08, and 12/29/08
DWC-73 forms from Dr. dated 05/05/08, 06/02/08, 07/07/08, 08/04/08, 09/02/08, 10/06/08, 11/03/08, 12/02/08, and 12/29/08
Designated Doctor Evaluations with , M.D. dated 05/13/08 and 09/02/08
An EMG/NCV study interpreted by , M.D. dated 06/16/08
A referral form from Dr. dated 10/08/08
An evaluation with , Ed.D. dated 11/17/08
A Physical Performance Evaluation (PPE) with , D.C. dated 11/17/08
A pre-certification request from Dr. dated 12/03/08
A letter of denial for 10 sessions of a pain management program, according to unknown criteria, from M.D. dated 12/08/08
An appeal request letter from Dr. dated 12/31/08
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from Dr dated 01/06/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 05/05/08, Dr. placed the patient on a Medrol Dosepak, Celebrex, and Lidoderm patches. On 05/13/08 and 09/02/08, Dr. felt the patient was not at Maximum Medical Improvement (MMI). An EMG/NCV study on 06/16/08 showed moderate bilateral carpal tunnel syndrome. On 11/03/08, Dr. recommended a pain management program. On 11/17/08, Dr. also recommended a pain management program. A PPE with Dr. on 11/17/08 indicated the patient could function at the sedentary physical demand level and a pain management program was recommended. On 12/03/08, Dr. wrote a pre-certification request for a 10 day pain management program. On 12/08/08 and 01/16/09, Dr. wrote letters of non-authorization for the pain management program. On 12/31/08, Dr. wrote an appeal request for the pain management program.

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

A chronic pain management program is only medically reasonable and necessary if all other appropriate medical treatment and evaluation options have been exhausted. In this case, that is clearly not the case. This patient has not had any documented formal physical therapy for treatment of carpal tunnel syndrome nor has she even had any documented trial of wrist splints. In fact, there is no documentation of this patient ever attending any physical therapy, although there is clear documentation of her refusal to do so when it was ordered

by Dr. on his initial visit. Moreover, a chronic pain management program is not considered medically reasonable or necessary unless patients demonstrate no evidence of secondary gain issues and no avoidance of return to work. Therefore, since this patient has clearly not exhausted all appropriate medical treatment options, is avoiding return to work, and appear to have secondary gain issues from her alleged work injury, she is clearly not an appropriate candidate for a chronic pain management program. Moreover, this patient has never demonstrated any significant evidence of either depression or anxiety nor have her test scores ever demonstrated any significant evidence of such conditions. This patient, therefore, has no demonstrated medical need for psychological services, and certainly not in a tertiary care setting such as a chronic pain management program. Therefore, the recommendations for non-authorization of 10 sessions of a chronic pain management program are upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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 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)**