

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: June 30, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Chronic Pain Management 5 x 2

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

MD, 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This patient has a date of birth of xx/xx/xx. He reported an injury xx/xx/xx while working. The injury is described as repetitive. The patient had a right trigger finger release xxxxx. An MRI xxxxx showed cyst like area palmar surface and tenosynovitis flexor digitorum. On xxxxx there was exploration of the right hand/finger with tenolysis of the tendons and neurolysis of radial and ulnar digital nerves. On xxxxx there was a carpal tunnel release and neurolysis of the median nerve. He uses Lyrica, lortab, buspar, ultram, amitriptyline and Prozac. An FCE shows he is capable of light medium physical demand. He has a BDI of 50. Work hardening was denied. He has had 18 individual psychologic sessions and 6 sessions of biofeedback. He has decreased sleep, weight gain and has increased smoking. He has a 12th grade education.

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

Chronic pain programs are recommended when there is access to programs with proven successful outcomes such as decreased pain and medication use. There are negative predictors of success for a chronic pain program as outlined in the ODG. This patient has just one negative predictor – increased smoking. He has already had surgeries without benefit. At the time of the request his injury was less than two years old. The patient meets

the criteria for a trial of a chronic pain program. The request does meet the ODG guidelines. Medical necessity exists for Chronic Pain Management 5 x 2.

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

ACOEM-AMERICA 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)