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Notice of Independent Review Decision

DATE OF REVIEW: 06/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10-day trial of chronic pain management

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

Board Certified Orthopedic Surgeon

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.

10-day trial of chronic pain management

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the right hand interpreted by an unknown provider (no name or signature was available) dated 07/07/09

An operative report from M.D. dated 07/07/09

Evaluations with, M.D. dated 08/20/09, 09/02/09, 09/09/09, 09/23/09, and 11/19/09

A behavioral medicine evaluation with. dated 10/14/09

An evaluation with M.A., M.Ed., L.P.C. dated 12/31/09

Psychological testing results from Ph.D. dated 01/28/10

An evaluation with Dr. and Dr. dated 03/16/10

A chronic pain management plan and goals of treatment form from, D.O. and D.C. dated 03/16/10

A Physical Performance Evaluation (PPE) with Dr. dated 03/16/10

An evaluation with, D.O. dated 03/30/10

A chronic pain management program request from an unknown provider (no name or signature was available) dated 04/07/10

A preauthorization request dated 04/07/10

A notice of non-authorization, according to the Official Disability Guidelines (ODG), from, M.D. dated 04/07/10

A reconsideration request from the same unknown provider dated 04/30/10

A notice of non-authorization, according to the ODG, from, M.D. dated 04/30/10

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On xx/xx/xx, Dr. performed a repair of the flexor digitorum profundus of the right middle finger, open reduction and internal fixation of the right middle finger, complex washout and debridement of the skin, subcutaneous tissue, and bone to the right index finger and right middle finger, and a complex repair of the laceration to the fingers. On 08/20/09, Dr. performed a steroid injection and applied a splint to the middle finger. On 10/14/09, Dr. and Dr. recommended a minimum of six weeks of individual psychotherapy. On 01/28/10, Dr. recommended 10 sessions of a chronic pain management program. On 03/30/10, Dr. also recommended a chronic pain management program. On 04/07/10, Dr. wrote a letter of non-authorization for the chronic pain management program. On 04/30/10, Dr. also wrote a letter of non-certification for the pain management program.

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

In my opinion, no. This claimant has what appears to be pain in his amputation stump in his finger as a result of a work related injury from xx/xx . This chronic pain began as a result of the amputation that he had as a result of osteomyelitis. I would not recommend a chronic pain management program as I do not think this claimant is a candidate for one. In addition, this is not the usual treatment of postamputation pain with regards to the finger. Therefore, the chronic pain management program is not reasonable at this time.

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
- 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)