



Notice of Independent Review Decision
Revised – omitted date of this revised report (page 1)

REVIEWER'S REPORT

DATE OF REVIEW: 03/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program five days a week for two weeks at eight hours per day

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Neurology with Added Qualifications in Pain Management, fellowship trained in Pain Medicine

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
309.0	97799		Prosp	10	11/30/09 – 01/22/10				Upheld

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial, 12/02/09 and 12/31/09
3. Pain management therapy goals, appeal letter, 12/21/09, and request for IRO, 02/05/10
4. Functional Capacity Evaluation
5. Behavioral Medicine evaluation, 10/26/09, 11/12/09
6. Physical assessment evaluation and treatment plan, 11/17/09
7. Nerve conduction studies, 05/06/09
8. MRI scan report, 01/16/08
9. Office visit and followup notes, 10/01/09 through 12/03/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant sustained a work-related injury on xx/xx/xx when she twisted her left hand while lifting a number of heavy packages. The pain has mainly involved the left hand and wrist with symptoms including numbness and tingling. She has undergone one-third reefer removal of a synovial cyst of the left wrist but with ongoing pain. Further studies reportedly demonstrated some mild findings of possible carpal tunnel syndrome, but a carpal tunnel release surgery was denied by the insurance carrier. This claimant has undergone some physical therapy, some medication trials including nonsteroidal anti-inflammatory

medication, and some individual psychotherapy sessions. Due to ongoing symptoms as well as some emotional symptoms that are felt to be consequent to the chronic pain as well as the denial of further surgery by the insurance carrier, treatment in a chronic pain management program was requested.

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

I essentially agree with prior reviewers that the usual and customary treatment options have not yet been exhausted prior to the use of a chronic pain management program. I agree that there remain treatment options that have not yet been explored, at least via the records that I have available, that are usually considered reasonable prior to the consideration for a chronic pain management program.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)