

SENT VIA EMAIL OR FAX ON  
Apr/28/2010

## **P-IRO Inc.**

An Independent Review Organization  
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### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**

Apr/27/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management Program X 10 sessions

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

Clinical psychologist; Member American Academy of Pain Management

**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**

OD Guidelines

Denial Letters 1/27/10 and 2/17/10

Balance 11/4/09 thru 3/31/10

Progress Notes 7/14/08 thru 9/9/08

OP Reports 7/2/08 and 9/14/06

Muscle Test 3/9/10

FCE 11/4/09

Dr. 6/20/08

Pain 12/18/09 thru 3/19/10:

**PATIENT CLINICAL HISTORY SUMMARY**

Initial medical eval dated xx/xx states "This is a male who presents today for an initial evaluation of his left wrist and forearm pain. The patient condition started when he fell from a height of 9 feet while performing his job and received a direct trauma to his left hand and wrist. The patient forearm was x-rayed and revealed at that time fracture of the distal radius.

The patient was treated conservatively and then surgically with plate and screws procedure. The patient's fracture healed but the patient was diagnosed with left median nerve injury at the level of the distal forearm and wrist. The patient developed at that time severe pain which was different than the initial pain as well as loss of strength, sensation in the medial aspect of the hand. The patient received physical therapy with mild improvement of the function but the pain remained high. The patient's pain is also associated with severe weakness, coolness of his left hand and wrist, sweating and burning sensation in the palm. As a result of the patient's pain he has problems sleeping in the form of falling asleep when his pain is high and often he is awakened by sharp shooting pain. The patient describes himself as being depressed since the time of the injury but he denies any thought or ideation of harming himself."

Records indicate that over the course of his treatment, patient has received x-rays, MRI's, injections, surgery x 2 to the wrist, physical therapy, FCE, individual therapy x 6, and medications management. Diagnoses have included: RSD, causalgia, chronic pain syndrome, s/p crush injury of the left hand and wrist, wrist joint pain, neuralgia, and chronic myofascial pain syndrome. Patient is currently in an off-work status.

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

ODG states that "an adequate and thorough evaluation" has to have occurred, which should include baseline functional testing so follow-up with the same test can note improvement or lack thereof. Unfortunately, there is no current behavioral re-eval available for review. The only behavioral record submitted for review is a 5-month old initial eval, with recommendations for individual therapy. Patient is reported to have made good progress with this, significantly decreasing his depression and anxiety scores. Based on this, there is now a request for the first ten days of a chronic pain program. Although patient may be appropriate, there is not currently enough information available to establish medical necessity

TDI-DWC has adopted the ODG treatment guidelines as the standard for non-network workers' compensation claims. Based on ODG criteria and the records submitted for review, the current request is deemed not medically reasonable and necessary at this time.

#### **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)