

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program Trial For 10 Days (80 Hours)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management
Board Certified in Electrodiagnostic Medicine

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

Official Disability Guidelines

HDI, 2/22/10, 3/23/10

Injury 1 2/16/10, 3/15/10, 3/29/10, 1/18/10

PPE 12/15/09

D.O. 12/15/09

8/24/09

Testing Inc 4/7/09

M.D. 7/23/09

PATIENT CLINICAL HISTORY SUMMARY

This xx year old man was injured on xx/xx/xx when he fell and lacerated his right arm. He required surgery with apparent ulnar artery and nerve repair and tendon repair. He underwent a revision for a contracture in 3/09. Scarring was noted. He underwent an electrodiagnostic study in 4/09 that showed radial sensory compromise bilaterally, but otherwise symmetrical ulnar amplitudes, velocities and F latencies. Dr. noted the ulnar sensory deficits in July 2009. He had clawing. Dr. saw him in 12/09 and described pain, the contracture, but not the sensory exam. His medications at that time did not include hydrocodone. These were mentioned in the assessment in 1/18/10. He is right handed and does manual labor.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The patient does not have any of the negative predictors of efficacy of treatment as described in ODG. This man has had some improvement with the psychological treatment he has received to date. He has not participated in a chronic pain program before. His nerve was described as 30% lacerated. The records demonstrate that previous methods of treating his chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Based on the medical records reviewed and the criteria described in the ODG, the reviewer finds that medical necessity exists for Chronic Pain Management Program Trial For 10 Days (80 Hours).

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)