



Notice of Independent Review Decision

DATE OF REVIEW: 10/29/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5x Week x2 Weeks for Ten Days

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

Board Certified in Physical Medicine & 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)

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.

Chronic Pain Management Program 5x Week x2 Weeks for Ten Days – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Chiropractic Therapy, Chiro & Physical TX, 03/25/10, 03/26/10, 03/29/10, 03/30/10, 04/01/10, 04/05/10, 04/07/10, 04/12/10, 04/14/10, 04/16/10, 04/19/10, 04/21/10, 04/21/10, 04/23/10, 04/26/10, 04/28/10, 05/05/10
- Evaluation, D.C., 04/08/10, 06/18/10, 07/07/10
- Functional Capacity Evaluation (FCE), Dr. 04/08/10, 06/18/10, 07/07/10
- Electrodiagnostic Testing, M.D., 04/27/10
- Evaluation, M.D., 05/10/10
- Evaluation, Healthcare Systems, 06/10/10
- Basic Interpretive Report, Unknown Provider, 06/10/10
- Work Hardening Program, Unknown Provider, 06/14/10, 06/18/10, 06/19/10, 06/20/10, 06/21/10, 06/25/10, 06/26/10, 06/27/10, 06/28/10, 07/01/10, 07/02/10, 07/03/10, 07/04/10, 07/05/10, 07/10/10, 07/11/10, 07/12/10, 07/18/10, 07/19/10
- Medical Contract, Unknown Provider, 06/24/10
- Pre-Certification Request, Rehabilitation Center, 07/16/10
- Patient Referral and Intake Form, Healthcare Systems, 07/16/10
- Examination Findings, Healthcare Systems, 07/22/10
- Denial Letter, 07/27/10, 08/23/10
- Request for an Appeal, Rehabilitation Center, 08/16/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that the date of injury was listed as xx/xx/xx. It was documented that the patient developed pain in the right upper extremity when she was pouring a gallon of milk into an expressor machine. She received at least sixteen sessions of chiropractic treatment from 03/25/10 to 05/05/10 at the Clinic.

The patient received an evaluation at the Clinic on 04/06/10. On that date a Functional Capacity Evaluation (FCE) was accomplished. It was documented that the claimant's pre-injury job activity level required the claimant to lift a maximum weight of 30 pounds on an occasional basis. The FCE indicated she was capable of "light to medium" work activities. It was felt she was a good candidate for treatment in the form of a work conditioning program or work hardening program.

An electrodiagnostic assessment of the upper extremities was obtained on 04/27/10. It should be noted that there were no symptoms referable to the left upper extremity with respect to the work injury of xx/xx/xx. The electrodiagnostic study revealed no findings worrisome for an active cervical radiculopathy in the right upper extremity or left upper extremity. There were findings consistent with what was described as a moderate carpal tunnel syndrome on the right upper extremity.

The patient was evaluated by Dr. on 05/10/10. This physician recommended that she be provided a Medrol DosePak. It was also recommended that she receive treatment in the form of a carpal tunnel injection.

A psychological evaluation was accomplished at the Healthcare System on 06/10/10. It was documented that the patient had a history of wrist pain “for a couple of years.” It was documented that she was not a participant in work activities. The report indicated there was a previous history of mental health treatment in 2009 for treatment of postpartum depression. It was recommended that the patient receive access to treatment in the form of a work hardening program.

The patient received at least nineteen sessions of treatment in a work hardening program from 06/14/10 to 07/19/10.

An FCE on 07/07/10 disclosed that the patient’s pre-test heart rate was 71 beats per minute and the post-test heart rate was 72 beats per minute. The FCE report was described as a “relatively reliable” study.

On 07/16/10 the patient underwent an evaluation at the Rehabilitation Center. It was documented that she was on tramadol (a non-narcotic medication used for management of pain symptoms). She was capable of lifting up to twenty pounds. It was recommended that the patient receive access to treatment in the form of a comprehensive pain management program for a total of twenty sessions.

The patient received an evaluation at the Healthcare System on 07/22/10. Specifically, on this date she was evaluated by Dr.. It was recommended that she receive access to treatment in a multidisciplinary comprehensive pain management program, and it was documented that the patient was with a diagnosis of tenosynovitis of the right wrist.

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

The date of injury is approximately months in age. Since the date of injury, the claimant received access to treatment in the form of chiropractic treatment as well as a work hardening program. The records available for review indicate there has not been a significant improvement in functional gains despite an attempt at treatment in the form of an extensive amount of chiropractic treatment as well as a work hardening program. Per criteria set forth by Official Disability Guidelines, medical necessity for a comprehensive pain management program would not presently be established. Given the fact that there is a documented lack of any significant progress with respect to previous attempts at rehabilitation services, the prognosis for any significant benefit for treatment in the form of a comprehensive pain management program would be considered to be poor. Hence, it would appear that there is evidence for a negative predictor with respect to a positive response to treatment in the form of such an extensive program. Additionally, as noted above, a Functional Capacity Evaluation accomplished on 07/07/10 appeared to not be a fully valid study. Official Disability Guidelines would not support a medical necessity for a comprehensive pain management program when there is documentation to indicate that there may be secondary gain issues/failure to recovery present that affect treatment

options with respect to the injury of xx/xx/xx. Additionally, the records available for review document that there is a medical diagnosis of a moderate carpal tunnel syndrome in the right wrist. It would not appear that there has been a previous attempt at an injection to the right carpal tunnel, and the records available for review do not formally document if there is an indication for any type of an invasive procedure with respect to the right wrist and the diagnosis of a carpal tunnel syndrome. The records available for review do not indicate that narcotic medications are required for management of pain symptoms. Consequently, per criteria set forth by the above-noted reference, medical necessity for treatment in the form of a comprehensive pain management program is currently not established.

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 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)**
- AMA GUIDES 5TH EDITION**