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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 5xWk x 2Wks, 80 hours Left Hand 97799

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Utilization review 06/21/11
Utilization review 07/06/11
Request for medical dispute resolution 07/13/11
Request for services 06/09/11
Functional capacity evaluation 06/07/11
Radiographic report left hand 01/05/11
Clinical records Dr.
Initial interview 02/15/11
Functional capacity evaluation 04/06/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who's reported to have sustained a work related injury on xx/xx/xx while working. On the date of injury he was reported to be shrink wrapping pallets when the shrink wrapper malfunctioned. His left hand was pulled into the machine and he was unable to dislodge it. When he was finally able to dislodge his hand he is reported to have had significant bleeding and severe pain. He was evaluated by a company doctor where he was treated and returned to work. His pain was so severe that he went to the hospital later that night and he has not been able to return to work since the date of injury. The claimant has been followed by Dr. DC for treatment. Treatment has included x-rays, ultrasound, physical therapy, chiropractic care, pain injections, and a TENS unit. The records include an x-ray report dated 01/05/11, which reports that the middle finger distal phalanx tuft is mildly comminuted and has no significant displacement or angulation. There is no extension to the distal interphalangeal joint no additional fractures were identified. Records indicate that on 06/09/11 the claimant was recommended to participate in a chronic pain management program. It is recommended to help the claimant deal with his depression anxiety and pain

symptoms associated to both psychological factors and a generalized medical condition. It's noted that his Beck depression inventory two score was 21 within the moderate to severe range and his and after completion of individual therapy sessions this was reduced to 19 still within the moderate to severe range. Beck anxiety inventory was 14 in the mild range and after completion of individual psychotherapy sessions his score was 15. A functional capacity evaluation was performed as part of the recommendation.

On 06/21/11 non-certified the request and notes that the claimant has participated in 10 sessions of a work conditioning program and that it is unclear as to functional improvement during prior treatment. It is reported that the claimant has increased left wrist motion. However most recent functional capacity evaluation fails to indicate the claimant's current physical demand level.
There is a lack of significant functional deficits of a left wrist range of motion to warrant continuation of therapy. He notes it is also unclear as to whether or not the claimant is taking any pain medications. He writes that the available data does not support certification of the request. An appeal request was reviewed by PhD. He notes that the claimant has not made significant progress with previous individual psychotherapy sessions or work conditioning program and that the claimant presents with mild psychological symptoms and that there is no indication that the claimant is improving with the treatment completed to date. As such he non-certified the request. A letter of appeal in request for dispute resolution was submitted on 07/13/11 at which time Dr., PhD notes that the claimant has exhausted all lower levels of care and is pending no additional procedures. This note did not provide additional data to refute the previous recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The records that were reviewed indicate that the claimant sustained a minor tuft fracture of the middle finger. It would appear from the records that this also required a laceration repair. The claimant has undergone physical therapy however no physical therapy records were submitted. The claimant has previously participated in recovery programs such as work conditioning and individual psychotherapy and upon completion of individual psychotherapy the claimant's levels of depression still remained elevated in the moderate to severe range and the claimant's anxiety index increased by one point. Based upon the review of the medical records there is no clinical indication for a chronic pain management program in this instance and the available clinical record does not support or establish medical necessity. Chronic Pain Management 5xWk x 2Wks, 80 hours Left Hand 97799 is not medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)