



## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 02/02/11

**IRO CASE #:**

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

10 Sessions Chronic Pain Management Program

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

Board Certified In Chiropractics

**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.

10 Sessions Chronic Pain Management Program - OVERTURNED

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

Medical documentation reviewed included a 06/23/08 surgical operative report from Hospital indicating the patient presented with a fresh injury of laceration as well as open displaced fracture of the proximal third phalanx on the right hand. The recommended procedure for the condition was open reduction and percutaneous pin fixation as well as repair of the A2 pulley of the right third finger and also repair of the laceration of the right fourth finger. The surgical report was signed by M.D. A laboratory report dated 06/24/08 also from Hospital confirms that the specimen submitted was a bone fragment tissue.

On 06/27/08 the patient underwent a follow up surgical procedure at Hospital again under the care of Dr. At that time the procedure was a tissue debridement secondary to necrosis of the third digit of the right hand.

On 07/16/08 the patient again underwent surgical intervention for the right third finger again with Dr., this time for a wide debridement. On 07/18/08 the patient was again seen for surgical intervention at Hospital with Dr. for an irrigation and debridement of the right third finger.

On 07/28/08 the patient presented for the final surgery with Dr. at Hospital, at which time the resulting procedure was an amputation of the right third finger. Indication was also made in the surgical note that the patient was a xx-year-old male who presented with a history of having a crane hook fall on his hand, resulting in extensive crush injury to the right third finger primarily.

Documentation dated 02/01/10 was an initial evaluation at Services with, D.C. It indicated the patient had a crane hook fall on his hand resulting in damage to the right third digit as well as the fourth digit and other parts of his hand. He was complaining of pain and numbness as well as tingling, burning, and weakness in the right hand. He also was continuing to have anguish over the loss of the digit and the resulting cosmetic deformities from the surgical intervention. Treatment notes indicated the patient had undergone occupational therapy during his hospital stay of approximately a one-month period back in 2008, but he had no treatment since then. Examination yielded a neurological deficit to the pinwheel and vibration as well as two-point discrimination of the right hand. It also indicated the patient had anger over the tissue deformity. The recommendation by Dr. was to refer the patient for a second opinion with a hand specialist as well as a psychological evaluation and referral for active rehabilitation for improvement of overall hand function.

On 05/26/10 the patient again presented to Office. This time he was seen by Dr., M.D. He was complaining of phantom pain in the right third digit as well as right hand pain. Recommendation was for the patient to continue medication. It was noted the patient was awaiting stellate block as well as a bone scan. It was recommended he continue physical therapy and follow up in one month.

On 06/23/10 the patient was again evaluated at Office, this time by Dr., M.D. He recommended that the patient follow up with Dr. about a prosthesis for the right third digit. Recommendation was also made to continue the medications that were prescribed for pain and sleep.

On 07/22/10 the patient presented for a post Designated Doctor Evaluation with M.D. His impression was that the patient had an impairment rating deficit secondary only to the amputation. He had no other residual dysfunction, had normal range of motion and return to full duty. In regard to the amputation percentage, he indicated the patient would qualify for 11% whole body percentage of permanent impairment.

On 08/10/10 there was a letter from Office regarding the IME evaluation by Dr.. It was signed by D.C. It indicated he agreed with the 11% for the amputation but not with the assessment the patient had full range of motion of the remaining digits, indicating that those findings contradicted the existing medical documentation as well as the previous Designated Doctor Evaluation which showed deficits in range of motion and function. He also was concerned that the patient was indicated he could return to full duty without any kind of documentation regarding his return to work duties or any proper assessment for his actual functional abilities on that date.

On 08/18/10 the patient underwent a psychological evaluation at Office. This was performed by, LPCI who was overseen by, Ph.D. Recommendation was made for ten trial sessions of a chronic pain management program secondary to the psychological evaluation findings.

On 09/08/10 there is a physical therapy note from Office performed by an unknown provider, no signature.

On 09/15/10 the patient returned for a follow up evaluation at Center with Dr.. He again recommended follow up with Dr. for a prosthesis as well as continuation of the medication for pain and inflammation.

On 09/16/10 there was a request for ten sessions of chronic pain management submitted by Dr., D.C. at Medical.

On 10/13/10 the patient was again evaluated for a follow up evaluation at Office. Notation was made that the patient was feeling better and he was currently in a work hardening program and appeared to be helping with the addition of the medication, as well. Recommendation was to continue the work hardening program as well as the medications prescribed by Dr..

On 10/13/10 the patient also had a follow up psychological evaluation again overseen by Dr. Ph.D. Notation was made that the patient had undergone ten trial sessions of chronic pain management as well as continuation of medication since the previous visit. He indicated that all psychological measurements were slightly worse except for the disability index, which was slightly improved. He was recommending an additional ten sessions of chronic pain management.

A Functional Capacity Evaluation was performed on 10/21/10 by an unknown provider. The company name was. The findings were that the patient could function in a

sedentary physical demand level, and again recommendation was made for chronic pain management program.

The patient was again seen at Center on 11/10/10 by Dr.. Notation was made the patient had completed two weeks of work hardening with having good results. Recommendation was to continue the work hardening as well as the use of the medication.

On 12/01/10 the patient was seen at Office by Dr. Again recommendation was made for chronic pain management, ten sessions. A letter dated 12/10/10 by Dr. also recommended ten sessions of chronic pain management.

On 12/07/10 there was a letter from Company, denying the request for chronic pain management program secondary to the issue that there is no evidence of any functional gain as a result of the previous treatment or no indication that the patient was compliant with treatment recommendation.

Dated 12/09/10 was a Designated Doctor Evaluation by, M.D. His impression was that the patient was at maximum medical improvement as of 06/28/10 and had a 14% whole body percentage of permanent impairment.

On 12/15/10 the patient was again seen at Office by Dr.. He recommended the patient continue medications and follow up in one month and to follow up with surgeons to see if any other options may be available for the patient's condition.

On 12/20/10 there was a letter submitted by, D.C. requesting reconsideration for ten sessions of chronic pain management.

On 12/22/10 there was a letter of clarification submitted by Dr. from Office regarding the Designated Doctor Evaluation on 12/09/10 by Dr.. He indicated that the two-point discrimination discrepancies that Dr. found in his examination should have been applied and would have increased the patient's impairment evaluation to 19%.

There was a letter dated 12/23/10 from Office by Dr. again with a recommendation for reconsideration of the chronic pain management program, ten sessions.

On 12/27/10 another letter from Provider denied the request for chronic pain management program, indicating the patient was at maximum medical improvement as previously found by other physicians and that previous recommendations were made for the patient to return to work full duty.

Final documentation is a letter dated 01/12/11 from Office. It was a SOAP treatment note performed by an unknown provider, with no signature. It was noted that the patient was taking higher doses more frequently due to pain. It was further noted that an IRO was pending and the patient was to return to the clinic for follow-up in 30 days.

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

Based upon the ODG Guidelines criteria for use of a multidisciplinary pain program, the

patient qualifies under Section 1 with chronic pain syndrome with evidence of loss of function that has persisted beyond three months and has evidence of three or more of the following: it is secondary to physical deconditioning due to disuse and/or fear avoidance of physical activity due to pain; (c) withdrawal from social activities, normal contact with others including work, recreation, and other social activities; (e) development of psychosocial sequelae that limits function or recovery after the initial incident including anxiety, fear avoidance, depression, sleep disorders, and nonorganic illness behaviors; (f) the diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) there is evidence of continued use of prescription pain medication, particularly those that may result in tolerance, dependence, or abuse without evidence of improvement in pain or function. Therefore, my recommendation is for allowing the additional ten sessions of chronic pain management program for this patient. The guidelines specifically make a recommendation for limitation of twenty sessions, which the patient will reach by completion of this second ten-session time.

**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 5<sup>TH</sup> EDITION**