

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/31/2011

**IRO CASE #:**

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

80 hours of Chronic Pain Management Program

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

MD, Board Certified Physical Medicine & Rehabilitation & Board Certified 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**

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a XX year-old female whose date of injury is XX/XX/XXXX. On this date the patient was using a power drill at work and reported sudden onset of pain into the right hand. Initial assessment was carpal tunnel syndrome, ulnar nerve neuropathy, brachial plexus syndrome and cervical disc disorder. The patient has a prior history of left carpal tunnel release. EMG dated 07/18/03 revealed mild right carpal tunnel syndrome. The patient underwent right carpal tunnel release on 11/05/03 without significant benefit. EMG/NCV dated 02/18/04 revealed mild residual median neuropathy at the right wrist. MRI of the right shoulder dated 04/05/04 revealed evidence of sprain of the inferior AC joint ligament/capsule with fluid in the AC joint. Follow up note dated 05/06/04 indicates that the patient underwent a second right carpal tunnel release a few days ago. Follow up note dated 05/20/04 indicates that the patient's pain is much worse than it was before. There is a gap in treatment records from this date until history and physical examination dated 03/10/10. The patient complains of constant right shoulder and arm pain. PPE dated 03/31/11 indicates that current PDL is light. Psychosocial evaluation dated 03/31/11 indicates that the patient is currently taking antidepressant medication and has attended individual psychotherapy in the past. BDI is 40 and BAI is 38.

Initial request for chronic pain management program was non-certified on 04/07/11 noting no clear documentation if the primary reason for treatment in the program is addressing possible substance abuse issues or to prevent or avoid controversial or optional surgery. Negative predictors of success have not been identified and addressed, and there is no indication that previous methods of treating right wrist and upper extremity pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The denial was upheld on appeal dated 04/21/11 noting lack of documentation that the patient has failed conservative treatment. The patient's injury is more than 24 months old. There are no drug screening tests provided to monitor for the patient's compliance of medications.

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

Based on the clinical information provided, this request for 80 hours of chronic pain management program is not found by the reviewer to be medically necessary. The patient sustained injuries almost x years ago. The Official Disability Guidelines do not support chronic pain management programs for patients whose date of injury is greater than 24 months old as there is conflicting evidence that chronic pain programs provide return to work beyond this period. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program.

**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)