

Notice of Independent Review Decision

**DATE OF REVIEW:** 11/03/2011

**IRO CASE #:**

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

80 Hours Chronic Pain Management Program for Left Hand

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics.

**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.

Upon independent review, I find that the previous adverse determination and adverse determination on appeal should be upheld. The *ODG* criteria have not been met for the requested service.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 23 page fax 10/14/11 IRO request, 38 page fax 10/14/11 URA response to disputed services including administrative and medical records. Dates of documents range from 01/08/11 to 10/14/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant has a date of birth of xx/xx/xxxx. She was working on xx/xx/xx and when a cabinet tilted, fell and crushed her left hand. She complains of left hand and finger pain. She has had physical therapy. She is taking Ultram for the pain. She has a diagnosis of depression and is taking Cymbalta. Her BDI is 17/63 and

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her BAI is 21/63. Her GAF is 65. On 5/2/2011 an MRI shows nonspecific strain of the extensor tendon of the 4<sup>th</sup> digit at the PIP without rupture. She did have a behavioral medicine evaluation on 9/1/2011 that showed evidence of pain behaviors. EMG showed neuritis of the left ring and left median neuropathy. She has the ability to function at a sedentary level according to FCE and her job is reported as a medium work level job.

There is a request for a chronic pain program.

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

Chronic pain programs are recommended where there is access to programs with proven successful outcomes, such as decreased pain and medication use, improved function and return to work and decreased utilization of the health care system. There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. The patient should ***show evidence of motivation to improve and return to work and meet the selection criteria***. The predictors of failure in a CPP are poor work adjustment and satisfaction, a negative outlook about future employments, high levels of pretreatment depression, pain and disability, increased duration of pre-referral disability time, higher levels of opioid use and elevated pre-treatment levels of pain.

This worker has not exhausted all lower and more conservative forms of care. She has depression and has not had psychotherapy. An anti-depressant has been started and the response is not documented. She has had bilateral hand injuries and FCE shows she is a light medium capacity. She has not been referred for work hardening with goal of return to work. Work hardening would be an appropriate level of care with psychotherapy. There is evidence of neuritis on EMG. There has not been a referral to pain management for injections. Medications have not been utilized – she is only on Ultram and the effectiveness has not been documented.

**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)