

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional chronic pain management x 10 days left thumb (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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines and Treatment Guidelines

Cover sheet and working documents

Utilization review determination dated 08/05/11, 08/29/11

Request for 10 final days of CPMP dated 06/22/11

Reconsideration request dated 08/22/11

PPE dated 08/19/11, 07/08/11, 06/16/11, 04/28/11

Office visit note dated 06/08/11, 10/05/10, 10/07/10, 10/13/10, 10/14/10, 10/19/10, 10/20/10,

10/21/10, 10/29/10, 10/28/10, 11/04/10, 11/05/10, 11/17/10, 12/01/10, 12/16/10, 01/17/11,

02/10/11, 02/28/11, 03/16/11, 03/10/11, 03/17/11, 03/21/11, 03/25/11, 04/01/11, 04/08/11,

04/18/11, 04/26/11, 04/29/11, 05/02/11, 05/05/11, 05/06/11, 05/11/11, 05/12/11, 05/13/11,

06/16/11, 08/04/11, 06/30/11, 06/01/11, 05/17/11, 05/16/11, 05/02/11, 04/18/11, 04/04/11,

03/21/11, 03/07/11, 02/17/11, 01/19/11, 01/05/11, 12/23/10, 12/15/10, 11/11/10, 10/28/10,

04/21/10, 07/01/10, 07/15/10, 07/19/10, 07/21/10, 05/11/10, 07/23/10, 08/10/10, 08/17/10,

08/24/10, 09/17/10, 04/20/10, 06/08/11, 06/01/11, 07/14/11, 08/02/11, 06/07/11, 07/05/11

Individual psychotherapy note dated 02/15/11, 02/23/11, 02/28/11, 03/09/11, 03/16/11,

03/29/11

Urine drug screen dated 08/02/11, 08/04/11

Initial consultation dated 11/08/10

Designated doctor evaluation dated 09/23/10, 12/13/10, 01/27/11

CT left thumb dated 12/09/10

Radiographic report dated 10/28/10, 04/21/10, 05/11/10, 07/23/10

MRI left thumb dated 07/30/10

Operative report dated 12/23/10

Reassessment for CPMP continuation dated 07/11/11, 06/17/11, 04/28/11

Letter dated 09/09/11

Pain management team conference/progress note and psychotherapy note dated 06/07/11, 06/08/11, 06/09/11, 06/10/11, 06/17/11, 06/13/11, 06/14/11, 06/16/11, 06/20/11, 06/21/11, 06/23/11, 06/28/11, 06/29/11, 07/06/11, 07/01/11, 07/08/11, 07/05/11, 07/13/11, 07/12/11, 07/11/11, 07/14/11, 07/19/11

Transportation/lodging documentation dated 07/08/11

EMG/NCV dated 06/29/11

Environmental intervention note dated 08/05/11, 08/26/11, 01/06/11

History and physical dated 04/29/11

Report of MMI/Impairment dated 08/25/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient was lifting a steel plate when he got his left hand trapped and fractured his thumb. The patient underwent designated doctor evaluation on 09/23/10. The patient was determined not to have reached MMI and was recommended for additional intense physical therapy to increase range of motion of the left thumb. Treatment to date includes diagnostic testing, individual psychotherapy, physical therapy, flexor pollicis longus injection, chiropractic treatment, exploration and repair of extensive tendon tenolysis of the extensor and flexor pollicis longus and repair of vola plate of IP joint of the left thumb on 12/23/10. Note dated 06/30/11 states that the patient will need functional arthrodesis of the left thumb in order for him to return to gainful activity. The patient has completed 20 sessions of a chronic pain management program. The patient's PDL increased from light to light medium and required PDL is medium-heavy. The patient decreased Hydrocodone usage from 4-5 times per day to bid-tid prn. BDI improved from 19 to 8 and BAI from 16 to 7. Follow up note dated 08/04/11 indicates that the patient has participated in a pain management program. The patient states that overall he does not seem to be getting any better, but he finds ways to cope throughout the program. The note states, "apparently a pain management program that he is undergoing has not helped him significantly."

Initial request for chronic pain management program was non-certified on 08/05/11 noting that under normal circumstances the program should be completed after 20 full treatment days, and there is no information provided indicating why this case is different. Report of maximum medical improvement/impairment dated 08/25/11 notes that the patient has not reached MMI as surgical amputation of the left thumb has been recommended to obtain functional use of the left hand. The denial was upheld on appeal dated 08/29/11 noting that the patient has completed 20 days of the program and current evidence based guidelines generally do not support more than 20 full day sessions of the program. Beck scales are normal. The patient continues to take 3 Hydrocodone per day.

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

The patient has completed 20 sessions of the program to date. The Official Disability Guidelines do not generally support more than 20 sessions of chronic pain management program. The patient's physical demand level has only improved from light to light medium after 20 sessions of CPMP. Follow up note dated 08/04/11 states that the patient reports that overall he does not seem to be getting any better, but he finds ways to cope throughout the program. The note states, "apparently a pain management program that he is undergoing has not helped him significantly". Additionally, the patient has been recommended for further surgical intervention in the form of surgical amputation of the left thumb to obtain functional use of the left hand. Based on the clinical information provided, the request for additional chronic pain management x 10 days left thumb (97799) is not recommended as medically necessary, and the two previous denials are 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

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)