

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Dec/14/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Chronic pain management program  
80 hours 97799

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Pain Medicine

**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 medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that chronic pain management program 80 hours 97799 is not medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Operative report dated 03/29/12  
Operative report dated 05/24/12  
Peer review report dated 07/06/12  
Functional capacity evaluation dated 08/28/12  
Encounter summary dated 09/12/12  
Behavioral health assessment dated 09/27/12  
Designated doctor's evaluation dated 10/04/12  
Worker's comp initial report of examination dated 10/05/12  
Utilization review determination dated 10/17/12  
Three phase bone scan right thumb dated 10/19/12  
Appeal for chronic pain management program dated 11/08/12  
Utilization review determination dated 11/14/12  
Response to denial letter dated 11/21/12  
Letter of medical necessity dated 11/28/12

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. On this date the patient was bitten on her right thumb. The bite became infected and she was treated with antibiotics. Treatment to date includes repair of zone 1 and zone 2 extensor tendon right thumb on 03/29/12, excision of neuroma and epineural repair of the branch of the superficial radial nerve on 05/24/12, stellate ganglion block. Functional capacity evaluation dated 08/28/12 indicates that required PDL is medium and current PDL is sedentary-light. Behavioral health assessment dated 09/27/12 indicates that medications include Percocet, Nortriptyline, Gabapentin, Cyclobenzaprine, and Cymbalta, Methotrexate sodium, Orencia, folic acid and multivitamin. FABQ-PA is 24 and FABQ-W is 42. Diagnoses are depressive disorder, NOS, related to injury medical condition; and generalized anxiety disorder. BDI is 50 and BAI is 46. Designated doctor evaluation dated 10/04/12 indicates that expected MMI date is 12/16/12.

Initial request for chronic pain management program 80 hours was non-certified on 10/17/12 noting that the mental health evaluation is inadequate as an evaluation for admission to a comprehensive

pain rehabilitation program. The patient is on Orenzia and methotrexate, but there is no assessment of RA in the reports and no mention whatsoever in the medical assessments submitted. There is no assessment with respect to whether such may constitute any negative reinforcement of the patient's pain behavior and/or contribute directly to the present level of dysfunctional status, regardless of the present underlying orthopedic condition. There is no treatment plan, including intent or method for weaning the patient from the narcotic. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem. Appeal dated 11/08/12 indicates that the patient's rheumatoid arthritis is only present in both her feet, both of her knees and both of her elbows. There is no interaction or correlation of her rheumatoid arthritis with her dysfunction of her right thumb due to her work related injury. The denial was upheld on appeal dated 11/14/12 noting that there is no direct evidence that the patient has motivation to change and is willing to change her medication regimen or that the patient is aware that successful treatment may change compensation and/or other secondary gains. ODG states that there are limited studies about the efficacy of chronic pain programs for neck, shoulder or upper extremity musculoskeletal disorders.

Designated doctor evaluation dated 12/11/12 indicates that the patient's pain is rated as 7/10. On physical examination deep tendon reflexes are 2 throughout the bilateral upper extremities. Palpation of the bilateral upper extremities is within normal limits. Range of motion of the bilateral shoulders, elbows, wrists and left hand are within normal limits. The right hand revealed decreased range of motion. There is decreased sensation at the distal aspect of the right thumb. She has positive Tinel's at the scar site and positive hypersensitivity. Strength is rated as 5/5 throughout the bilateral upper extremities. Extent of injury is chronic regional pain syndrome. The patient is right hand dominant and the injury was to the right thumb. Subsequent neuroma and CRPS developed due to the hypersensitivity of the right thumb. She has had to alter how she holds a pen. Administrative/secretary duties are light duty but difficult if not impossible with her condition. Therefore, the patient's inability to perform the pre-injury employment from 08/08/12 to present is a direct result of the compensable injury.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Per behavioral health assessment dated 09/27/12, the patient's Beck Depression Inventory score is 50 and Beck Anxiety Inventory score is 46. Both of these scores are in the questionable range; however, there is no indication that the patient has undergone psychometric testing with validity measures to assess the validity of her subjective complaints. The patient's subjective complaints appear to outweigh objective findings. Despite severe reports of depression and anxiety, there is no indication that the patient has undergone a course of individual psychotherapy. Given the current clinical data, it is the opinion of the reviewer that chronic pain management program 80 hours 97799 is not medically necessary.

**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)