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Notice of Independent Review Decision

DATE OF REVIEW: 3-14-2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of chronic pain management 80 hours 97799.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the chronic pain management 80 hours 97799.

PATIENT CLINICAL HISTORY [SUMMARY]:

Worker was injured at work xx/xx/xx when she xxxxx, sustaining a fracture of the left wrist. The worker went to surgery xxxxx. The operative report was not made available for this review, but subsequent medical summaries mention that the procedure was "open reduction and internal fixation of the distal radius fracture, arthroscopy of the wrist and osteotomy of the distal third..." Treatment included physical therapy and medications. At the request of Dr., individual psychotherapy was requested and authorized. The initial behavioral medicine consultation was obtained November 14, 2011.

A physical performance evaluation was performed November 28, 2011 wherein the injured worker performed at a sedentary level of activity. Tests revealed decreased grip strength and

pinch strength in the involved hand. Based upon the examination findings the evaluator stated that the injured worker was unable to perform her regular job duties.

On December 1, 2011 Dr. wrote a prescription for evaluation and treatment for a return to work program (written "RTWP"). On the handwritten clinical follow-up note 12/14/2011, Dr. noted that authorization for the requested RTWP was still pending.

On January 11, 2012, after completion of the six authorized sessions of individual psychotherapy, a chronic pain management interdisciplinary plan was submitted, together with a revised treatment reassessment summary and request for additional services. Noting that the worker had responded well to individual psychotherapy, the examiner recommended evaluation for psychotropic medication and advised that the worker would best be served in an interdisciplinary program. The examiner stated that "if medically appropriate it is recommended the patient be approved for a tertiary program".

On January 19, 2012 a preauthorization request was submitted for the proposed chronic pain management program, 80 hours. In the request the examiner noted that the injured worker demonstrated dependence upon family members for basic activities of daily living, secondary physical deconditioning, limited participation in social activities, evidence of moderate depression, and continued use of prescription medications. The evaluator noted that prior treatment modalities had failed.

DIAGNOSTIC STUDIES

Reports from diagnostic studies were not submitted for this review. Some of the submitted records refer to test results, including an interpretation of an x-ray of the left forearm 2/4/2011, which reportedly showed a comminuted fracture of distal radius with dorsal displacement of distal fracture fragments and also a fracture of the ulnar styloid. One reviewer reported "suggestion of lateral radial head subluxation as per medical report dated 01/10/12 by Dr."

The proposed treatment program was non-authorized January 25, 2012. A request for reconsideration was submitted January 30, 2012. On reconsideration an adverse determination was made February 24, 2012.

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

Recommend denial of the requested service. Although the injured worker has chronic pain and meets some of the criteria for participation in a chronic pain management program, the records submitted for this review do not include documentation that all diagnostic procedures necessary to rule out treatable pathology have been completed. Specifically, in the THE ODG –TWC Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), updated 02/29/12, pertaining to criteria for the general use of multidisciplinary pain management programs: Criteria listed in item (3) include the following:

An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

Specifically, as noted in the DIAGNOSTIC STUDIES paragraph above, one reviewer mentioned “suggestion of lateral radial head subluxation as per medical report dated 01/10/12 by Dr.”. The records do not address if this condition was confirmed and if further treatment/stabilization/surgery is indicated for this condition prior to entrance to the chronic pain management program.

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)