IRO America Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW:
JULY 3, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Ten sessions of chronic behavioral pain management

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., American Board of Anesthesiology

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Employer's first report of injury, undated
Physical therapy initial evaluation, 12/11/02
Emergency Department note, 02/28/05
Request for leave of absence, 02/28/05 to 03/01/05
Lumbar spine x-ray, 02/28/05

Progress notes, 03/03/05, 03/17/05, 04/07/05, 04/21/05, 05/12/05, 06/28/05, 07/29/05, 08/26/05, 10/25/05, 12/02/05, 01/19/06, 02/20/06 and 03/27/06
Lumbar spine MRI and 3-D multiplanar MRI, 03/25/05
Office notes, Dr. 03/31/05, 03/31/05, 05/03/05, 08/04/05 and 10/18/05
Office notes, Dr. 04/26/05, 08/01/05, 11/15/05 and 04/03/06
Note, Dr. to Dr. 06/02/05
Operative report, 07/25/05
Office note, Dr. 08/25/05
Functional capacity evaluation, 08/30/05
Computerized range of motion and CMT testing, 10/18/05
Statement of medical necessity for CMT and range of motion, 10/18/05
RME, Dr. 01/05/06
Office note, Dr. 04/12/06, 05/10/06, 06/21/06, 07/19/06, 08/28/06 and 09/25/06
Office note, Dr. 04/25/06, 05/23/06, 06/20/06, 07/18/06, 08/15/06, 09/05/06, 10/10/06, 11/07/06, 12/05/06, 01/02/07, 01/30/07, 04/02/07 and 05/01/07
Office note, Dr. 05/30/06
Office note, Dr. 10/30/06
Independent Medical Evaluation, Dr. 02/08/07
Re-evaluation, PA, 02/27/07
Office note, Dr. 03/06/07
Physical performance evaluation, 03/19/07
Psychological evaluation, MS, LPC, 04/04/07
Request for chronic pain management program (ten session), 04/11/07
Impairment rating examination, 04/18/07
Report of medical evaluation
Review, Dr. 04/18/07
Appeal for chronic pain management program, 05/07/07
Review, Dr. 05/16/07
Request for independent review, 06/07/07
Independent Review Organization summary, 06/22/07
Note from compliance officer, 06/26/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a worker who injured his back while moving a pallet of glass at work. He was struck by a 40 pound box of detergent causing low back and radiating bilateral lower extremity pain. He was found by MRI on 03/25/05 to have a disc herniation and radial tear at L4-5 with impingement bilaterally and a bulging disc at L5-S1 without impingement. EMG/NCV studies on 04/26/05 were normal. He treated conservatively with therapy, various medications, off work, a lumbar epidural steroid injection and a lumbar facet injection at L4-5 and L5-S1 through 01/07. He also was treating for depression.

An Independent Medical Evaluation by Dr. on 02/08/07 noted findings including a slow and guarded gait, antalgic lean, tenderness to palpation of the lumbar spine, moderate hypertonic lumbar paraspinals, greater on the left, sluggish reflexes at the patella and hamstring on the left, increased pain with left lateral and forward bending, and positive straight leg raise. Dr. did not feel the claimant was at Maximum Medical Improvement and stated that if Dr. did not feel he was a surgical candidate that a strengthening program and a possible CT myelogram would be appropriate.

Dr. saw the claimant on 03/06/07 noting an antalgic gait and low back pain with sitting and supine straight leg raises. Otherwise the examination was normal. X-rays that day were normal. Dr. diagnosed the claimant with probable L4-5 discogenic pain and recommended continuation of conservative treatment including a multidisciplinary pain management program and permanent restrictions and job training. He did not feel the claimant was a surgical candidate and also recommended an updated MRI.

A physical performance evaluation on 03/19/07 noted that the claimant was currently functioning at a sedentary level of demand and his job required a medium level. The examiner agreed that a multi-disciplined pain management program was appropriate. On 04/02/07 Dr. recommended a CT myelogram and if he was deemed not a surgical candidate a chronic pain management program. The claimant was declared at Maximum Medical Improvement on 03/08/07 and assigned a 7 percent whole person impairment rating. The request for a chronic pain management program was denied on 04/18/07 and 05/16/07 and is now under appeal.

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

The claimant is a worker, who injured his back. Throughout his care, multiple physician examiners have documented clear pathology related to disc herniation and annular tear at L4-5 with impingement bilaterally, and disc bulging at L5-S1. This has been documented both by physical exam and MRI. This has not been conclusively proved by EMG, although physician examiners have contended that the EMG was performed too early. Physician examiners have not shown any evidence of symptom magnification and /or positive Waddell signs during examination. There is some element of depression, which after reviewing the documentation, appears normal for the degree of pain elicited during physical examination. This claimant also appears to meet Official Disability Guidelines for 2007. Therefore, chronic behavioral pain management appears warranted in this claimant.

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

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Pain Chapter – Chronic Pain Management Programs).

☐ 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)