



Notice of Independent Review Decision

DATE OF REVIEW: 7/3/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for the previously denied request for ten sessions of chronic behavioral pain management program.

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

Texas Licensed Orthopedic Surgeon.

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 previously denied request for

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheets/Authorization Request dated 6/26/07, 6/25/07, 6/22/07, 4/18/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/22/07.

- **Company Request for Independent Review Organization dated 6/21/07.**
- **Request for a Review by an Independent Review Organization dated 6/14/07.**
- **Notice to CompPartners, Inc. of Case Assignment dated 6/25/07.**
- **Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 6/25/07.**
- **Pre-Authorization Decision and Rationale dated 5/21/07, 4/24/07.**
- **Determination Report dated 6/25/07.**
- **Request for Appeal dated 5/11/07.**
- **Pre-Certification Request dated 4/18/07.**
- **Peer Review dated 5/19/07, (unspecified date).**
- **Summary (unspecified date).**
- **E-Mail Message dated 5/16/07, 5/14/07, 4/20/07, 4/19/07, 4/18/07.**
- **Pre-Authorization Request Receipt Confirmation (unspecified date).**
- **Weekly Summary Physical/Response to Treatment dated 4/18/07, 4/13/07, 3/30/07.**
- **Evaluation Report dated 3/12/07.**
- **Physical Performance Examination Report dated 3/16/07.**
- **Electrodiagnostic Study Report dated 2/19/01.**
- **Lumbar Spine Radiologic Report dated 6/13/00.**
- **Lumbar Spine Myelogram with CT Scan dated 8/26/03.**
- **Interdisciplinary Pain Rehabilitation Treatment Note dated 4/13/07.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: While unloading a patient from a vehicle, the wheelchair became stuck, and when the patient tried to dislodge the chair, she heard a pop and had burning sensations in the low back

Diagnosis: Status-post lumbar fusion in 1997 and re-fusion in 2000.

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

This female status post lumbar fusion x 2 was noted to receive physical therapy with TENS unit, ultrasound, massage, stretching, heat/ice, and topical analgesics, which were beneficial. As of the 3/12/07 evaluation by LPC-1, the patient was taking Darvocet-N 100, Zoloft 200 mg, Ambien CR 12.5 mg, and Skelaxin 800 mg. The evaluation performed on that date by LPC-1 noted the patient complaining of tolerable pain that was a dull aching sensation, leaving her feeling tired and avoiding activity. The TENS unit made the pain better. The patient reported the pain at a 1-2/10 currently, with average daily pain of 2-3 / 80 percent of the time. The DSM IV Diagnostic Impressions were: Axis I - chronic pain disorder with both psychological features and general medical conditions as a result of the work injury, major depressive disorder resulting from a work injury; Axis II - no diagnosis; Axis III - resulting from work injury of 9/23/96; Axis IV -

occupational problems, economic problems, problems with access to health care services; and Axis V - GAF currently 55 and prior to injury 81. It was felt the patient should be referred to an interdisciplinary chronic pain management program. At that time, it was felt the patient did meet the criteria outlined by the Official Disability Guidelines (ODG). As of the 5/11/07 note, the patient had completed ten sessions of her chronic pain management program with the patient having improved with a Beck Depression Inventory now of "18 versus an initial 29; pain scale is 1/10 and activity levels are moderate to high." It did indicate the patient had shown excellent progress with reduced subjective pain complaints and he improved daily activity levels. The report did indicate the patient continued to struggle with implementation of pain management strategies outside the treatment and her symptoms of depression fluctuated. The ODG criteria for the general use of multidisciplinary pain management programs are: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made. (2) Previous methods of treating the chronic pain have been unsuccessful. (3) The patient has a significant loss of ability to function independently resulting from the chronic pain. (3) The patient is not a candidate where surgery would clearly be warranted. (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change. Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The medical records provided for review do indicate that the patient has demonstrated evidence of subjective and objective gains indicating the ten sessions of chronic behavioral pain management as being appropriate.

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 AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
