

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW:
JULY 2, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic Pain Management (10 Sessions)

**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

Lumbar spine MRI, 02/05/01
Chest x-ray, 07/26/01
Infectious Disease consult, 08/08/01
Pathology report, 08/10/01
Office note, Dr., 02/21/07

Note, LCSW, 04/04/07
Request for pain management, 04/09/07
Office note, Dr., 04/06/07
Note, , 04/12/07 and 05/09/07
Appeal request, LPC, 05/02/07
Request for IRO
Computerized range of motion study

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who worked as a housekeeper. She has had apparently three lumbar surgeries including a fusion from L4-S1 in 07/01 followed by and infection that required removal of the bone growth stimulator with incision and drainage in 08/01. She had lumbar hardware removed in 2004. The claimant also injured her shoulder and required two shoulder surgeries.

She was seen on 02/21/07 by Dr., Pain Management for a Required Medical Examination. He noted that she had a chronic pain management program in 2005 that did not change her pain or ability to deal with pain. The claimant reported right shoulder pain, scapular pain, possible cervical pain, low back pain and right buttock and hamstring pain. She was taking Hydrocodone 5mg three times a day and Mobic. On examination sensation was intact in L1-S1. Strength was 5/5. Reflexes were 2 plus in the lower extremities. The neuro examination of the upper extremities was intact and there was 5/5 upper extremity strength. Reflexes were 2 plus. The impression was low back pain, chronic right shoulder pain and rotator cuff tear with 2 surgeries and 3 lumbar surgeries. He opined that the claimant needed no treatment other than pain medication.

On 04/04/07, LCSW, saw the claimant noting she was referred for behavioral health evaluation to determine if she was a candidate for a multidisciplinary pain management program. The claimant reported that she had pain 100 percent of the time. She was obese, well groomed and cooperative. The Beck depression inventory II revealed mild sadness, moderate negativity and difficulty making decisions. She scored 33/63. The Beck Anxiety inventory noted severe inability to relax, wobbly legs and other symptoms. She scored 17/63. The claimant related that she would like to be more socially active and more active around the house, and to decrease pain. These were felt to be realistic goals and 10 days in interdisciplinary pain management was recommended.

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

The claimant is a, who worked as a housekeeper until a low back injury. She has not worked since that time. She is on Social Security Disability. The claimant's last full medical review was done by Dr. He renewed medications and made no other recommendations. He did not require testing, therapy or make recommendations regarding further treatment. The Official Disability Guidelines for 2007 make it clear that patients must exhibit motivation to change and a willingness to forego secondary gain as

criteria for multidisciplinary pain program. The licensed social worker's statement of the claimant's desires matches a pattern that would be more closely matched to repetitive social services report rather than a concentrated pain management program. Therefore, the request for chronic pain management is not recommended as medically necessary.

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 Comp2007 Updates, Pain-Chronic Pain Management
- 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)**