

IRO America Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

Notice of Independent Review Decision

DATE OF REVIEW:

JUNE 15, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 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 or illness
Dr. medical report, 07/29/93
Dr. Orthopedic Center initial visit, 02/25/94
MRI lumbar spine, 02/26/94

Dr. second surgical opinion, 04/19/94
Operative report, Dr. 06/15/94 and 08/07/00
Dr. letters, 06/01/95, 02/26/96, 06/24/96, 03/27/98, 04/02/98 and 04/09/98
Functional capacity evaluation, 04/02/98 and 07/15/99
Office notes, Dr. 03/12/99, 09/16/99, 05/05/00, 06/16/00, 08/29/00, 01/14/03,
03/21/03, 05/16/03, 09/30/03, 12/04/03, 02/12/04, 06/14/04, 07/14/04,
10/01/04, 01/20/05, 05/12/05, 07/07/05 and 09/13/05
Case Management report, 07/12/99 and 09/07/99
History and physical, Dr. 08/07/00
Pre-certification request, 03/27/07
Medical director review, 03/30/07
LPC letter of appeal, 04/19/07
Medical director review, 04/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient injured her low back when she fell at work on. She was employed at the center as a driver, food server and janitor. Physical requirements were noted to be medium to heavy. The Patient treated with Dr. following her injury and was diagnosed with a herniated disc at L3-4 and L5-S1. On 06/15/94 she underwent a lumbar laminectomy on the right at L3-4 and on the left at L5-S1 with a posterior fusion at L5-S1. On 06/01/95 Dr. placed the Patient at maximum medical improvement with a 15 percent whole body impairment rating and she was placed on light duty work restrictions. It was felt that she was unable to return to her regular job.

The Patient was seen twice in 1996 for lumbosacral spine pain radiating to both lower extremities. She was treated conservatively and remained off work. Patient continued to treat for low back pain with radiation to both lower extremities. She had limited lumbar motion with muscle spasm. A functional capacity evaluation was done on 04/02/98 that demonstrated a light level of work capability.

In 1999 the Patient continued with lumbar discomfort, spastic paravertebral muscles and decreased range of motion. She was allowed activity as tolerated. She followed a home exercise program for range of motion and gentle stretching exercises. A functional capacity evaluation was done on 07/15/99 that again demonstrated light level of work capability. Records in 1999 indicate that the Patient underwent a vocational assessment with efforts at finding a job within her light duty work restrictions. There is no indication that the Patient returned to work at any point.

At the 09/16/99 visit with Dr., the Patient had no neurological deficits. She complained of occasional back pain that was controlled with conservative management. The diagnosis was post laminectomy syndrome. The Patient has

increased pain in 2000 that was felt to be related to the hardware. On 08/07/00 the Patient had removal of the hardware and revision of the spinal fusion with anterior cages. At the 08/29/00 visit with Dr. the Patient was doing well.

Dr. noted at this visit that the Patient had continued pain to the mid lower back and was unable to return to any gainful employment. Her chronic pain was treated with nonsteroidal anti-inflammatory medications and heat and stretching exercises. On exam she had a negative straight leg raise, mild spastic muscles to the mid lower back and some tenderness. Sensation and circulation were intact to the lower extremities. The Patient followed with Dr. every two to three months with no significant changes in her condition. Medications consisted of various nonsteroidal anti-inflammatory medications and Theragesic cream. These follow up visits continued throughout 2004 and 2005. The 05/12/05 note indicates pain radiating down the legs but there was no change in her exam findings. She had spasm and tenderness of the low back, decreased range of motion and good muscle strength and tone to the lower extremities. Medications were Mobic and Theragesic cream. The 09/13/05 note from Dr. stated that an MRI was done in June 2005 which revealed a herniated sequestered disc at L2-3 and also some problems at L5-S1. He felt that the problem was scar tissue more than anything else. The Patient was neurologically intact and a CT scan was ordered to assess the fusion. There was no indication whether this study was done as no further records were provided until 2007.

There is a pre-certification request dated 03/27/07 for an additional 10 sessions of Chronic Behavioral Pain Management Program. The Patient had completed ten sessions. The additional sessions were denied by the medical director. An appeal letter was submitted; however, the treatment was again denied.

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

The Patient is a female with a low back injury dating back. Good medical management has been unsuccessful despite multiple surgical procedures and modality care. The Patient had previous pain management with ten sessions in a rehabilitation pain program. The enclosed documentation does not make it clear that benchmarks were met and does not show that progress was sustained over time and/or strong motivational efforts were exhibited by the patient.

According to official disability guidelines promulgated by Texas, criteria for general use of multidisciplinary pain management programs includes documentation that the Patient has had significant loss of ability to function independently resulting from chronic pain, and that the patient exhibits motivation to change and a willingness to forego achievement of secondary gains with therapy. Consideration of these criteria should be met before additional

sessions are approved. Thus, the Reviewer agrees with the determination of the Insurance Carrier.

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, Chronic Pain
- 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)