

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 05/15/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Twenty sessions of chronic interdisciplinary pain management.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., D.O., M.S., Board Certified in, Pain Management

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Letter dated 01/08/07 – initial adverse determination
2. Letter dated 01/22/07 – appeal of adverse determination
3. Numerous letters from requestor, including a 01/10/07 letter PsyD
4. Numerous records from treating doctor (TD) beginning 11/02/05 and including 12/22/05, 02/16/06, 03/06/06, 04/13/06, 06/08/06, 08/03/06, 09/18/06, and 09/28/06
5. Consultation by TD for the chronic pain management program dated 12/14/06
6. Chronic pain evaluation report dated 11/03/06
7. On 12/14/06 she was taking Elavil, Darvocet, Clinoxide, carisoprodol, Fosamax, calcium, polyethylglycol, and gabapentin.
8. Physical therapy notes beginning on 12/26/06
9. Report dated 01/30/07
10. Required Medical Examination of 06/14/06 (examiner had apparently previously seen patient on 07/27/05, although I do not have that note)
11. X-ray report dated 06/14/06 which showed “facet arthropathy, solid L5/S1 fusion, internal wires probably from bone stimulator, stable when compared with last year’s x-rays”

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee is a female (as of xx/xx/xx). The injured employee developed lower back pain that was determined to be work related in xx. Following this she went on to have extensive treatment, which has included chiropractic care, physical therapy, injections, and medications. There were notes that she went through a functional recovery program known as, but that appears to have been an error. There appears to be confirmation in the records, but she never did go through any type of a functional restoration program.

Following this work event, the records do indicate that she had increased pain on xx/xx/xx while sweeping the floor. She had already undergone a lumbar discectomy at L5/S1 on 07/16/97, and then on 05/02/00 she underwent an L5/S1 fusion. She then had surgery to remove the wires from the bone stimulator. The records suggest she had significant psychosocial stressors and appears to be depressed. She is on multiple medications are noted above.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

At this point in time it is my opinion that the injured employee has a work-related back condition, which has been treated both conservatively as well as with two surgeries. She has been left with chronic post laminectomy-type pain, which has not been significantly responsive to treatment to date to the point allowing her to return to gainful employment and to reduce her requirements for medications. Based on the understanding that she has indeed never had the opportunity to pursue the functional recovery program, I do believe that, given her constellation of symptoms, clinical findings, and psychosocial stressors, that a 20-day trial of a chronic interdisciplinary pain management program may prove of some benefit to her.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- ACOEMd-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.

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- \_\_\_\_\_ 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 national accepted medical literature (provide a description).
- \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)