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## IRO REPORT

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**DATE OF REVIEW:** 5/1/07

**IRO CASE #:**

**NAME:**

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

Determine the medical necessity of the previously denied chronic pain management program, five times a week for six weeks (30 sessions).

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

Texas licensed Pain Management Physician and Anesthesiologist.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

[Check only one of the boxes above.]

Previously denied chronic pain management program, five times a week for six weeks (30 sessions).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Fax Cover Sheet dated 4/24/07, 4/23/07, 2 pages.
2. Fax Cover Sheet/Authorization Request dated 1/26/07, 1/19/07, 2 pages.
3. Notice of Case Assignment dated 4/23/07, 1 page.

4. **Notice of Assignment of Independent Review Organization dated 4/23/07, 1 page.**
5. **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/4/07, 1 page.**
6. **Company Request for (IRO) dated 4/3/07, 4 pages.**
7. **Request for a Review by an Independent Review Organization dated 2/2/07, 3 pages.**
8. **Determination Notification Letter dated 2/2/07, 1/24/07, 4 pages.**
9. **Program Authorization Request dated 1/26/07, 1/19/07, 2 pages.**
10. **Initial Interview Report dated 12/22/06, 9 pages.**
11. **Progress Note dated 3/2/05, 12/8/04, 10/13/04, 9/16/04, 8/18/04, 6/22/04, 14 pages.**
12. **Request for Reconsideration dated 1/25/07, 3 pages.**
13. **Initial Report dated 12/21/06, 3 pages.**
14. **Narrative time period: 7/15/04 thru 10/13/04, 4/15/04 thru 7/14/04, 3 pages.**
15. **Letter of Medical Necessity for Dyna Splint for the Left Knee dated 10/1/04, 1 page.**

#### **INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

**Patient's age:**

**Gender:** Female

**Date of Injury:**

**Mechanism of Injury:** Assaulted

**Diagnoses:** Cervical herniated nucleus pulposus (HNP); lumbar herniated nucleus pulposus; status-post total left knee.

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

The review of the information submitted indicated that this patient, who had an extensive work injury involving the neck, low back, and left knee from being assaulted in the classroom by a student. Following an initial period of conservative treatment, consisting of physical therapy and medication management, the claimant reportedly underwent cervical epidural steroid injections (ESI) and two left knee arthroscopies, and eventually a left total knee replacement in 2003. Accordingly, the claimant returned to work light duty in 2004 for several months, but was unable to continue working due to persistent neck and back pain complaints. Of note, no radiographic imaging study reports of the cervical and/or lumbar spine were submitted for this review. Despite multimodality conservative treatment, surgical intervention pertaining to the left knee and post-operative rehabilitation would include work conditioning, and aqua therapy. The patient continued to experience neck and low back and left knee complaints. Reportedly, from a chronic pain management initial interview report submitted, dated 12/22/06. This patient, due to the work related emotional distress she experienced because of the injury, participated in six sessions of out-patient psychotherapy with a psychiatrist in 2004. The patient reported that he does think that outpatient therapy was beneficial, at that time, and continued with emotional and residual pains symptoms. There were no notes submitted for review from the outpatient psychotherapy sessions. Behavioral testing performed on 12/22/06 revealed a Beck Depression Inventory (BDI) of 39 and chronic severe depression. Currently, the patient is complaining of low back, left knee, and left side of the neck pain, which radiated to her shoulder. She described her pain as a constant, stabbing, burning, dull, sharp, throbbing, shooting, and itching sensations with VAS (visual analog scale) 7 to 8/10. Current medication management consists of Darvocet N 100

(quantity/usage not specified). Interesting, no antidepressant medication prescribed for this patient. The narrative reports submitted from the orthopedic spine surgeon, MD, only review the facts and conditions of the patient's work related injury, and that in a check-off list, which include practice causing the patient inability to work. After reviewing the medical records provided, the request for 30 sessions of chronic pain management program has been denied. The clinical indication and necessity of the request could not be established. The patient already had physical therapy and behavioral treatment for the chronic pain complaints, and failed to improve. It appears that this patient is poorly motivated to get back to work. There was no documentation of prior anxiety and/or depression issues submitted prior to report requesting a chronic pain management program (CPMP). The claimant's current and required functional status is unclear at this time. It is unclear if the patient exhausted all surgical options. Accordingly, the main purpose of these programs are to return the patient back to work and also wean off the sedative medications to specifically return to some form vocation. This applies for one year and this injury is six years old. There is no peer review literature to support programs for the shoulder injuries.

**If applicable this section should include the following:**

- Specific basis for divergence from the Division of Workers' Compensation (DWC) policies or guidelines adopted under Labor Code §143.011.

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

[Check any of the following that were used in the course of this review.]

**X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.**

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition Chapter 6: Pain Suffering and the Restoration of Functions, Pages 113-114

- 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.

**X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.**

Official Disability Guidelines, Treatment Index, 5<sup>th</sup>. Edition, 2006/2007  
Pain Section-Chronic pain programs

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC 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.**

**You’re Right to Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers’ Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.