



DATE OF REVIEW: 10/3/07

Date of Addendum: 10/4/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for chronic 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 chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet dated 9/12/07, 7/20/07, (unspecified date).
- Letter/Attachments dated 9/11/07.
- Confirmation of Receipt of a Request for a Review dated 9/11/07.
- Request for a Review by an Independent Review Organization dated 9/10/07.
- Adverse Determination After Reconsideration Notice dated 7/31/07, 7/17/07.
- Notice to Copartners dated 9/12/07.
- Note dated 9/10/07.
- Progress Note dated 9/5/07, 8/8/07, 7/11/07, 6/13/07, 9/20/06, 9/10/06, 9/13/06, 9/1/06, 8/30/06, 8/21/06, 8/18/06, 8/16/06, 7/28/06, 7/26/06, 7/25/06, 7/12/06, 7/11/06, 6/29/06, 6/15/06, 6/13/06, 6/9/06, 6/8/06, 6/6/06, 6/2/06, 6/1/06, 5/25/06, 5/24/06, 5/23/06 5/18/06, 5/17/06, 5/15/06.
- Letter/Response to Denial Letter dated 8/10/07.
- Patient Information (unspecified date).
- Integrated Interdisciplinary Assessment Summary & Treatment Recommendations dated 7/1/07.
- Office Visit dated 3/20/07, 3/8/07.
- Letter/Response to Request for IRO dated 9/17/07.
- Chronic Pain Programs (unspecified date).
- Referral Form for Behavioral Pain Management and Rehabilitation (unspecified date).

- Letter/Follow Up Information dated 7/19/07.
- Initial Evaluation dated 5/15/06.
- Prescription Plan of Care dated 5/15/06.
- Progress Report dated 6/15/06.
- Exercise Log dated 9/20/06, 9/18/06, 9/13/06, 9/1/06, 8/30/06, 8/21/06, 8/18/06, 8/16/06.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Transferring containers.
Diagnosis: Lumbar strain; myofascial pain syndrome; and chronic pain syndrome.

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

This male was injured while transferring containers at work on xx/xx/xx. The xx/xx/xx initial evaluation indicated there was history of a prior back injury from several years ago. The patient denied numbness and tingling on that day. The physical examination noted pain rated at 7/10. There was decreased lumbar lordosis with a pelvic tilt posteriorly and moderate tenderness and spasm of the bilateral paraspinal musculature and sacral sulcus. The patient was then started on physical therapy, with the 6/15/06 report indicating the claimant continued to complain of intermittent low back pain with good and bad days. The physical therapy progress notes continue through 9/20/06, for a total of 26 visits. On 3/8/07, Dr. indicated the patient previously had an MRI that revealed mild facet degenerative changes and had been getting injection therapy with facet rhizotomies. It was noted the patient initially had 50% to 75% improvement with the facet injections, but the facet rhizotomies provided no relief. Dr. physical examination failed to reveal any focal neurological deficits and his assessment was L4-5 and L5-S1 lumbar facet syndrome. Medial branch blocks were recommended by Dr. and by his associate Dr. The patient was then seen 6/13/07 by Dr., whose assessment was chronic pain syndrome, lumbago, lumbar facet syndrome and tobacco use disorder. He prescribed Celebrex 200 mg and Lortab 10/500. Instructions were lifting precautions, muscle relaxer precautions, narcotic precautions and the patient was to return to work with restrictions. The 7/1/07 integrated interdisciplinary pain management assessment initial evaluation recommended the patient participated in a comprehensive interdisciplinary pain program. Dr. 7/19/07 report indicated the patient had been under her care since 1999, and was psychiatrically stable and was able to participate in a rehabilitation program. The 8/10/007 letter by Dr. in response to the denial addresses each Official Disability Guidelines criteria with **succint** information for each criteria. (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement (Dr. describes that adequate and thorough violation and his rebutal letter); (2) Previous methods of treating the chronic pain have been unsuccessful (the medical records were replete with the patient having failed prior treatment); (3) The patient had a significant loss of ability to function independently resulting from the chronic pain (both Dr. and the multidisciplinary pain management initial evaluation documented the loss of ability to function independently); (4) The patient is not a candidate where surgery would clearly be warranted (the patient's

evaluation by Dr., an orthopedic spine specialist, documented he was not a surgical candidate); (5) The patient exhibited motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change (again Dr. and the multidisciplinary chronic pain management evaluation documented the patient's motivation to change); & (6) Negative predictors of success above have been addressed (This reviewer feels the medical records document any negative predictors have been addressed). 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 2 weeks without evidence of demonstrated efficacy, as documented by subjective and objective gains. This reviewer feels the patient is a candidate for the multidisciplinary pain management program, per the Official Disability Guidelines criteria on a two week trial with re-evaluation to demonstrate the efficacy as documented by subjective and objective gains per the criteria.

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 KNOWLEDGBASE.
- 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 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.
