



## REVIEWER'S REPORT

**DATE OF REVIEW:** 08/08/08

**IRO CASE #:**

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

Medical necessity of detoxification/functional restoration program.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine and Rehabilitation, and 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. I have reviewed an EMG study report from Dr. dated 08/31/01, which was “normal.”
2. X-rays of the lumbar spine on 07/17/02 read by Dr. showed on AP view “two Ray cages, L5/S1, excellent position of the cages.”
3. MRI scan of the lumbar spine on 08/07/02 showed “surgery has been carried out at L5/S1. Cages are noted at L5/S1. There is no evidence of infection at this disc level. Modic I changes are noted at the inferior endplates at L5. There is a large saucer-shaped pus-containing cavity in the extradural space measuring 4 mm. Posterior to this saucer-shaped pus-containing cavity, there is involvement of the posterior spinal muscles, mainly the multifidus muscle. These muscles contain phlegmon with particular destruction consistent with pus. These muscles are contained by the deep fascia. There appears to be involvement of the right piriformis muscle. This muscle involvement stretches from the level of L3 to S3. The lumbar spine is within normal limits.” This is signed by Dr..

4. X-rays of 08/02/02 show “cages are noted at L5/S1. There is no evidence of infection at the disc space. Soft tissue swelling is noted, however, posteriorly. These latter findings have been elaborated on the MRI scan.”
5. I reviewed a 09/13/02 MRI scan report of Dr., discussing an abscess in the posterior epidural space that has now become loculated.
6. X-ray report of 10/5/02 from Dr. shows “successful posterior left paraspinous fluid collection aspiration under fluoroscopic guidance with CT scan confirmation.”
7. There was a myelogram report of 05/19/05 reviewed from Dr.. Note was made of the previous surgery without any evidence of significant impingement or arachnoiditis.
8. There was a note from Therapy and Diagnostics dated 10/18/07, which was a computerized muscle testing assessment.
9. I reviewed a 02/19/08 letter from, Ph.D., regarding interdisciplinary pain rehabilitation programs as an outpatient.
10. I reviewed an operative report of 10/14/08, which was removal of hardware by Dr..
11. I reviewed a report dated 04/30/08 from Dr.. He notes, “The patient has a chronic pain presentation at the present time, and I do not see that I can improve his pain behavior. After removing the screws, I do not have to see him any longer.”
12. On 05/01/08 there was noted some improvement by Dr. . He was on OxyContin, Klonopin, and Lortab at the time. He was diagnosed with failed spine surgery syndrome, and the plan was for repeat surgery.
13. On 07/30/08 he was seen by Dr. with anxiety and depression levels escalating. He was recommended for detoxification and functional restoration program.
14. I reviewed a 07/16/08 note from Dr..

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

This is a gentleman without reportedly had developed back pain at work on xx/xx/xx and went on to have various diagnostics, an L5/S1 fusion, the development of an abscess, surgical drainage of the abscess, removal of hardware, and postoperative back pain. He has been on various medications. There has been no recent functional examination of his spine nor a comprehensive psychiatric consultation but rather a psychological evaluation as part of the functional services report of 07/16/08. There was some discussion that he had a third surgery, but it does not appear documented that it took place or that it is still being planned.

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

It is my belief that he is not in need of a detoxification or functional restoration program for several reasons. He does not have a clearly defined clinical assessment of his spine and understanding of what his goals might be as related to ameliorating the back pain, specifically to the point where he can reduce his reliance on pain medications. It is not clear if he is having another surgery or not. He does appear to have some problems with depression, which are identified in this progress note. However, there does not appear to have been any comprehensive psychological or psychiatric intervention as an outpatient to date. I believe that under the ODG Guidelines the patient would not qualify for this type of a program if surgery was warranted. At one point it was suggested, and it is not clearly defined that another surgery is not going to be performed. He appears to have a

valid reason for back pain, and there is no indication that there has been abuse of the medication or that there are strategies that can be implemented in the functional restoration program that cannot be implemented outside that type of program that would assist in reduction of his medications.

**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.)*

- 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 judgment, 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 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.)