CompPartners

Notice of Independent Review Decision

DATE OF REVIEW: **2/18/08**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for chronic pain management, 20 sessions.

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:

X 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.

The previously denied request for Chronic pain management, 20 sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- **Notice of Assignment of Independent Review Organization dated 2/7/08.**
- **Request Form dated 1/25/08.**
- **Patient Profile dated (unspecified date).**

- **Prescription dated 2/8/08, 12/17/07, (unspecified date).**
- **Progress Report dated 4/28/07.**
- **Employment Return to Work Agreement dated 9/6/07.**
- **Pre-Authorization Request dated 9/6/07.**
- **Data Report dated 10/23/07.**
- **Psychosocial Assessment Report dated 10/24/07.**
- **Notice of Denial of Pre-Authorization dated 11/9/07.**
- **Comments dated 12/11/07.**
- **Confirmation of Receipt dated 2/7/08.**
- **Notice of Reconsideration dated 12/11/07.**
- **Notice of CompPartners, Inc. dated 2/7/08.**
- **Treatment Plan (unspecified date).**

No guidelines were provided by the URA for this review.

PATIENT CLINICAL HISTORY (SUMMARY):
Age:
Gender: Female
Date of Injury:
Mechanism of Injury: Repetitive lifting of heavy boxes.

Diagnosis: L5-S1 disk herniation, right; left foraminal narrowing with central stenosis, L5-S1; and lumbar pain.

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

The claimant has been treated with conservative therapy. There has been an MRI performed which confirmed an L5-S1 disk herniation right, with left foraminal narrowing. The orthopedic evaluation performed by D.O., on April 28, 2007, noted injection in the shoulder gave some relief and it was gradually getting better with Dr.'s conservative care. Dr. was seeing the claimant for the lumbar spine and physical examination revealed decreased motion with muscle spasm and tenderness over the paravertebral musculature. Lasegue's was negative. Patrick's was negative. There was no weakness noted in either lower extremity. Patellar and Achilles reflexes were equal and active bilaterally. The claimant could heel and toe walk and there were no neurological or vascular deficits noted. Dr. noted the claimant had extensive physical therapy and rehabilitation. The claimant had received facet blocks and epidural injections. He noted no trigger points and no evidence at all of a radiculopathy or facet disease. He felt the claimant's problem of the left shoulder was responding and that he was not a candidate for any surgery or injections. He felt the chronic pain management program was appropriate. In the medical records provided for review, the reviewer did not find any evidence of objective clinical findings of neurological or orthopedic impairments that substantiate the claimant's subjective complaints. It is of note that the functional capacity evaluation indicated a significant lack of full

effort on the claimant's part with almost all the activities significantly reduced because of complaints of pain. The claimant had started a work hardening program but only attended three sessions and dropped out due to subjective complaints of increased pain. In discussion with Dr., chiropractic physician, Dr. agreed whole heartedly that there were no neurological or orthopedic impairments, and the subjective complaints appeared to far outweigh objective findings.

The rationale for an adverse determination for the chronic pain management program of 20 sessions is this reviewer does not feel the claimant meets Official Disability Guidelines, Web-Based criteria for chronic pain management, with the conflicting evidence of the functional capacity evaluation, and the claimant not being able to sustain a work hardening program, one does not see where a multidisciplinary chronic pain management program will be of any further benefit, and this reviewer does not believe the ODG Guidelines support the chronic pain program at this time.

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

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

(1) An adequate and thorough evaluation has been made.

(2) Previous methods of treating the chronic pain have been unsuccessful.

(3) The patient has a significant loss of ability to function independently resulting from the chronic pain.

(3) The patient is not a candidate where surgery would clearly be warranted.
(5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.
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.
Inpatient admissions for pain rehabilitation may be considered medically necessary only if there are significant medical complications meeting medical necessity criteria for acute inpatient hospitalization.
(BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC 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).