



IRO REVIEWER REPORT

DATE OF REVIEW: 1/9/08

NAME:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness for the previously denied request for 10 sessions of chronic pain management program.

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

Texas licensed Anesthesiologist.

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)

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 10 sessions of chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to CompPartners, Inc. of Case Assignment dated 1/2/08.
- Fax Cover Sheet Message dated 11/12/07.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 1/2/08.
- Confirmation of Receipt of a Requests for a Review by an Independent Review Organization dated 1/2/08.
- Provider That Received the Denial (unspecified date).
- Request for a Review by an Independent Review Organization dated 12/20/07.
- Review of Reconsideration has been Completed Report dated 12/13/07.

- Notification of Determination dated 11/20/07.
- Office Visit Letter dated 11/28/07, 7/25/07, 5/25/07.
- Evaluation dated 10/19/07.
- Brief Narrative Letter dated 11/12/07.
- Request for an Appeal Letter dated 12/4/07.
- Examination dated 10/22/07, 7/25/07.
- Progress Notes dated 10/22/07, 7/25/07.
- Treatment Plan/Quality of Care dated 11/13/07, 11/7/07.
- Interdisciplinary Pain Rehabilitation Program dated 11/14/07, 11/13/07, 11/12/07.
- Mental and Behavioral Health Consultation and Progress Note dated 11/12/07.
- Response to Treatment dated 11/7/07.
- Outpatient Order/Scheduling Fax Form 12/5/07.
- Weekly Summary Medical Response to Treatment dated 11/7/07.

NO GUIDELINES WERE PROVIDED BY THE URA FOR THIS REFERRAL.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Slip and fall.

Diagnosis: 723.1 Cervicalgia, 722.0 Displacement of Cervical Intervert.

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

The claimant is a male who sustained a work related injury, involving the cervical spine, secondary to a slip and fall mechanism. Subsequent to the injury, the claimant underwent an extensive amount of conservative treatment consisting of physical therapy, chiropractic treatment, medication management, and interventional pain management injections with unsustained relief. The patient eventually required a cervical fusion. From the initial healthcare system chronic pain management evaluation report, dated October 19, 2007, the claimant's type of work prior to the accident, included digging with a shovel, climbing, running a backhoe, and a lot of heavy lifting. The patient had been employed for almost years. In addition, the claimant continued to work one month after his injury. The claimant reportedly is not currently working and would like to return to work but states "he does not think he will be able to because of his neuropathy/diabetes." A summary of initial psychological testing prior to performing chronic pain management program revealed a Beck Anxiety Inventory of 29 and a Beck Depression Inventory of 23. In the appeal letter and a request for an appeal correspondence, dated December 4, 2007, following 10 sessions of chronic pain management program, the claimant's Beck Anxiety Level decreased to what appears to be 23; there appeared to be no documentation of a reduction of the Beck Depression Inventory. Current medication management continues to remain at Norco six a day, Zanaflex 4 mg b.i.d., and Lyrica 75 mg b.i.d. After review of the information submitted, the previous non-authorization for an additional 10 sessions of chronic pain management program has been upheld.

Based on the documentation provided, there was a lack of significant progress relative to functional restoration, both objectively and subjectively. There appears to be no significant improvement in the claimant's psychosocial issues, i.e. anxiety/depression from the scores submitted. In addition, the main purpose of these programs is to return a patient back to work and to wean him from sedative medications, so they can return to some form of vocation. It appears from the information provided, that there has been no titration of opioid medication with the initial 10 sessions of the chronic pain management program. Furthermore, the success rate for patients who return back to work is reduced drastically after one year. Given that there is no peer-reviewed literature to support programs for older injuries, and the injuries in this case were sustained more than two and one-half years ago, the likelihood that the outcome of ten additional sessions of a chronic pain management program would result in this particular claimant's return to work is remote, at best. Based upon all of the foregoing, the intervention in question cannot be recommended.

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 KNOWLEDGEBASE**
ACOEM Guidelines, 2nd Edition, Chapter 6.
- 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**
Official Disability Guidelines, Treatment Index, 5th Edition, 2006/2007 under Pain Section-Chronic Pain Program.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**
Behavioral Treatment for Chronic Low Back Pain: A systematic review within the framework of the Cochrane Back Review Group, Spine, 2001, February.