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Notice of Independent Review Decision

Date of Review: 06-18-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of Chronic Pain Management

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

Certified by The American Board of Anesthesiology
Anesthesiology - General
Pain Medicine

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective		97799	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Notice dated, 04-25-08
Adverse Determination After Reconsideration Notice dated, 05-27-08
Notice of Denial of Compensability / Liability and Refusal to Pay Benefits dated, 01-28-08
Patient Profile
Physicians prescription-chronic pain management dated, 04-04-08
Pre-Authorization Request for Chronic Pain Management start date, 04-28-08
Authorization Notice dated, 02-19-08
Pre-Authorization Request - Additional Chronic Pain Management - IRO Position Statement
ERGOS Supporting Data Report dated, 03-25-08
Consultation note dated, 04-04-08
MRI Lumbar Spine – Final report dated, 12-27-07
Lower Extremity Electrodiagnostic Study dated, 12-19-07
Individual Chronic Pain Management Schedule and Treatment Plan
Official Disability Guidelines (ODG) Treatment –Integrated Treatment/Disability Guidelines, Pain (Chronic): not provided

PATIENT CLINICAL HISTORY:

The patient was injured and presented with lower back pain. A MRI examination of the lumbar spine revealed at L5-S1 a posterior annular tear and posterior, slight of midline, 2mm disc protrusion/herniation contacting the proximal left S1 nerve root within the subarticular recesses with mild spondylitic changes at this level. The patient also had an EMG that demonstrated a left sided S1 radiculopathy. The patient has undergone a home exercise program, a physical therapy program, a work hardening program which had to be discontinued due to an intense level of pain, and attempted a return to work trial but was unable to meet job demands due to the high pain levels. The patient is currently on Ultracet and Cymbalta for the management of his pain symptoms.

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

The Reviewer commented that the provided documentation substantiates little insight to the patient's current pain symptoms to include location (although the chief complaint is low back pain and a progress note from the provider states that

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the symptoms include “but is not limited to pain, spasticity and numbness”), there is no reference to aggravating or alleviating maneuvers, referred pain locations or neurological deficits. The patient has not undergone any interventional pain procedures or been evaluated for surgical intervention.

The Reviewer noted that ODG states that 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, including baseline functional testing so follow-up with the same test can note functional improvement.
2. **Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.**
3. The patient has a significant loss of ability to function independently resulting from the chronic pain.
4. **The patient is not a candidate where surgery or other treatments 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.
6. Negative predictors of success above have been addressed.

In the opinion of the Reviewer, based on the medical documentation provided, ODG criteria #2 and #4 are not met. There are many interventional pain therapies that may be considered for treatment of patient’s pain symptoms before a chronic pain management program is warranted. Therefore, the requested sessions of chronic pain management program is not medically necessary for this patient.

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**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

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- 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 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)