



Notice of Independent Review Decision

DATE OF REVIEW: 6/17/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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

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

Texas licensed Psychiatrist.

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 a chronic pain management program times 10 sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Independent Review Organization Summary dated 6/11/08.
- Fax Cover Sheet/Message/Note dated 6/9/08, 8/9/06.

- Notice of Assignment of Independent Review Organization dated 6/9/08.
- Notice to CompPartners, Inc. of Case Assignment dated 6/9/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/9/08.
- Company Request for Independent Review Organization dated 6/9/08.
- Request Form Request for a Review by an Independent Review Organization dated 6/6/08.
- Request Letter for a Chronic Pain Program Extension to be presented for Medical Dispute Resolution dated 5/25/08.
- Peer Review Determination Notification dated 5/16/08, 4/29/08.
- Medical Conference with Physician dated 5/16/08, 4/29/08, 5/15/06, 4/28/06, 8/4/04.
- Pre-Authorization Request Letter for the Chronic Pain Program (10 days), (reconsideration) dated 5/7/08.
- Official Disability Guidelines regarding Chronic Pain Program (unspecified date).
- Individualized Plan of Treatment dated 4/22/08.
- Pre-Authorization Request Letter for the Chronic Pain Program (10 days) dated 4/22/08.
- Psychosocial Assessment Report dated 4/17/08.
- Consultation for Chronic Pain Program Report dated 4/17/08.
- Written Chronic Pain Rehabilitation Contract dated 4/17/08.
- Referral Form dated 3/27/08.
- Follow-Up Visit Note dated 3/27/08, 1/2/08, 12/11/07, 11/9/07, 8/15/07, 6/4/07, 3/28/07, 2/7/07, 6/6/06, 3/8/06, 2/8/06, 12/21/05, 9/21/05, 6/2/05, 3/21/05, 2/16/05, 1/12/05, 11/17/04, 10/20/04, 9/14/04, 2/5/04, 1/8/04, 12/10/03, 10/29/03, 9/17/03
- Procedure Report dated 1/2/08, 4/23/03, 6/16/05.
- Chronic Pain Evaluation Report dated 12/11/07, 11/17/04.
- Functional Capacity Evaluation Report dated 11/16/07, (unspecified date).
- Notice of Disputed Issue(s) and Refusal to Pay Benefits dated 2/14/07.
- CompPartners Peer Reviewer Final Report dated 8/9/06.
- Initial Physical Therapy/Occupational Therapy Evaluation Report dated 3/23/06.
- Health and Behavioral Intervention Discharge Summary dated 10/19/05.
- Health and Behavioral Intervention Note dated 10/6/05, 9/29/05, 9/22/05, 9/15/05, 5/13/05, 5/5/05, 5/3/05, 4/28/05, 4/26/05, 4/21/05, 3/11/05, 3/9/05, 3/4/05, 3/1/05, 2/25/05, 2/24/05, 2/18/05, 2/16/05.
- Notification of Suspension of Indemnity Benefit Payment dated 4/12/05.
- Impairment Rating Report dated 4/11/05.
- Report of Medical Evaluation dated 4/11/05.
- Chart Note dated 2/16/05, 3/10/04, 3/3/04, 2/18/04, 11/14/03, 4/11/03, 4/8/03.

- Lumbar Spine Myelogram and CT Scan dated 2/10/05.
 - Interval History dated 11/17/04.
 - Health and Behavioral Initial Assessment dated 11/9/04.
 - Correspondence dated 10/26/04, 9/27/04.
 - Independent Review Report/Letter dated 9/17/04.
 - Cover Page/Surveillance/Investigation Report dated 8/27/04, 4/15/04
 - History/Physical/Neurological Examination Report dated 7/21/04.
 - Texas Workers' Compensation Work Status Report dated 7/21/04, 7/28/03, 5/5/03, 4/23/03, 4/16/03, 4/8/03.
 - Benefit Dispute Agreement dated 7/04.
 - Payment of Compensation or Notice of Refused/Disputed Claim (unspecified date).
 - Evaluation Report/Letter dated 4/25/04, 3/12/04, 7/28/03, 4/22/03.
 - Employer's First Report of Injury or Illness.
 - Referral Letter dated 1/15/04.
 - Peer Review Report dated 1/8/04.
 - Evaluation/Progress Report/Letter dated 12/14/03, 12/10/03, 9/19/03, 9/5/03, 8/25/03, 8/20/03, 7/25/03, 5/19/03, 5/5/03.
 - Independent Medical Evaluation Report/Letter dated 11/17/03.
 - Anesthesia Record dated 10/20/03, 10/6/03.
 - Operative Report dated 10/20/03, 10/6/03, 6/10/03, 9/17/03.
 - Initial Patient Examination Report dated 9/10/03.
 - Symptom/Pain Index/Diagram/Questionnaire dated 7/23/03.
 - Observation Monitoring Form dated 7/21/03.
 - Examination Report dated 7/23/03, 6/25/03, 5/5/03, 4/23/03, 4/16/03.
 - Lumbar Spine Myelogram/Post-Myelogram Lumbar Spine CT Scan/Lumbar Spine X-Ray Report dated 7/21/03.
 - Texas Outpatient Authorization Recommendation Report dated 5/19/03.
 - Daily Treatment Record dated 5/14/03, 5/12/03, 5/5/03, 5/2/03, 4/30/03, 4/28/03, 4/24/03, 4/22/03.
 - Authorization Request Log dated 5/13/03.
 - Lumbar Spine MRI dated 4/30/03.
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- Sedation Monitoring Form dated 4/30/03.
 - Observation Monitoring Form (Post-Procedure CPT: 99499) dated 4/30/03.
 - Texas Outpatient Voluntary Non-Certification Recommendation dated 4/28/03.
 - E-Mail Message/Retrospective Review Report dated 5/13/03.
 - Literature regarding Chronic Pain/Functional Restoration Programs (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:
Mechanism of Injury: Lifting injury

Diagnosis: Chronic pain, bilateral lumbar radiculopathy, neck pain, lumbar and cervical disc disease.

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

The claimant is a female who was injured at work while working as a . She was lifting heavy items of dog food and in the process injured her back. Since the injury, she had experienced chronic low back pain radiating to the right and left buttocks. There was also right and left leg pain into the feet with numbness and tingling. She also felt burning and pain in the hips and thighs from prolonged sitting or walking. A lumbar myelogram done on 02/10/05, revealed a two millimeter disc bulge at L2-3 and L4-5 levels. The claimant had lumbar degenerative disc disease as a pre-existing condition which was exacerbated by her lifting injuries at work. The claimant developed a chronic pain syndrome characterized by somatic preoccupation, pain sensitization, muscle tension, depression, anxiety, anger and alienation. The claimant had a decreased social life and currently lives with her three children. She reported difficulty with all household activities as well as driving. She had an extensive amount of conservative treatment consisting of physical therapy, medication management, psychiatric care, counseling, a myriad of multiple tests including a lumbar MRI and lumbar myelogram. She also received pain management procedures including lumbar epidural, steroid injections and lumbar facet joint injections and trigger point injections. She had her last trigger point injection on 01/02/08. She has currently exhausted all primary and secondary levels of care. The claimant meets the Official Disability Guidelines (ODG) criteria for the general use of a multidisciplinary pain management program. She was adequately evaluated and had a significant loss of ability to function independently resulting from chronic pain. She is currently not a candidate for surgery. She is motivated for change. She had exhausted primary and secondary levels of pain management without much success. There were some concerns about negative predictors for Chronic Pain Management Program (CPMP) as to her motivation and for her being on Social Security disability. However, the claimant expressed her desire to return to work and in the last year she had delivered pizzas for approximately a month. She was also looking into the possibility of having a home-based business. The claimant did not have a negative relationship with her employer/supervisor. The claimant had no issues with poor work adjustment and satisfaction. In fact, the claimant had a positive outlook about future employment. In the past, the claimant had high levels of psychosocial stress but as the medical records indicated, she had sought treatment not only through Workers' Compensation, but had also seen a counselor on her own. The claimant was not involved in any financial disability disputes. The medical records indicated that the claimant did not smoke. The duration of per-referral disability time was appropriate in that this claimant had been referred to the Chronic Pain Program in 2006. The claimant was no longer on any opioid medications. This determination is consistent with the ODG which state: "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, 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; (3) The claimant has a significant loss of ability to function independently resulting from the chronic pain; (4) The claimant is not a candidate where surgery would clearly be warranted; (5) The claimant 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. Integrative summary reports 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. The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine." - Pain (Chronic) ODG Integrated Treatment/ Disability Duration Guidelines

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.

- 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).