

SENT VIA EMAIL OR FAX ON  
Jul/11/2009

# Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/09/2009

**IRO CASE #:**

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

80 hours of Chronic Pain Management Program between 6/10/09 and 8/9/09

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

Clinical psychologist; Member American Academy of Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 5/27/09 and 6/17/09

Health 9/28/07 thru 6/17/09

Dr. 5/19/09

PPE 5/19/09

Radiology Reports 1/30/07

OP Report 12/4/07

Diagnostics 5/14/07

MRI 3/21/07 and 3/9/07

Work Conditioning Program 1/20/09

8/5/08

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a work-related injury on xx/xx/xx. Patient was driving a company vehicle when records indicate another motorist drove through a red light, hitting the

claimant head-on. Claimant's head hit the steering wheel, but he describes no LOC. He established treating with Dr. after unsuccessfully trying to receive attention at a clinic. Patient continues to experience headaches and cervical and lumbar pain. Patient continues to remain in an off-work status, but relates that he would like to return to work in his previous occupation, if possible.

Over the course of his treatment, patient has received x-rays, cervical and lumbar MRI's (positive), EMG/NCV (positive for neuropathy/possible S1 radiculopathy), surgery x 1 to be a microdiscectomy, and has been treated conservatively with active and passive physical therapy, individual therapy, medication management, and post-surgical therapy. Elective cervical surgery has been recommended, but patient has declined due to lack of expected results from his lumbar surgery.

Designated doctor exam of 4-10-07 stated that work injury extended to spine injury and headaches and reported that patient was not at MMI. Medications currently include Hydrocodone 10/325 mg qd and Methocarbamol 1 tid.

At the time of the initial eval for CPMP, claimant was exhibiting the following symptoms: pain level of 6-7/10, difficulty sleeping, cervicogenic headaches, burning sensation in his knee, and reduced physical, social, and emotional capabilities. FCE conducted 5/21/09 showed good participation from the patient, with current PDL at Light-Medium. Required PDL is Heavy. BDI score was 14, FABQ was 42, 24, Oswestry was 26, and patient showed some negative coping strategies. Patient denies any history of pre-existing depression or ADL problems prior to the injury. Current diagnoses include: Chronic cervical, lumbar and right knee pain and chronic pain disorder associated with both psychological factors and a general medical condition. Patient was evaluated on 5/13/09, where they found the following: on a scale of 1-10, patient rated a 9/10 for the following: irritability, anxiety, and sleep problems. He rates pain and frustration at a 7/10, and tension at a 5/10. The goals to be achieved are: increased physical performance demands as delineated in the FCE, decrease BDI from 14 to 7, decrease pain from 6-7/10 to 3/10, increase sleep from 3 to 6 hours, decrease frustration from 7/10 to 3/10, reduce muscle spasms without the use of Methocarbamol, reduce anxiety from 9/10 to 3/10, and reduce irritability from 9/10 to 3/10.

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

Patient has continued pain post-surgically, and is electing a more conservative approach pain management currently versus another surgery, which ODG supports. Patient has received evaluations from a medical doctor, a psychologist, and his treating physician, all of whom agree patient needs a CPMP. Previous methods of treating the pain have been unsuccessful, and patient is attempting to forego another surgery. Patient appears to have followed all doctor recommendations to this point, and reports motivation to continue to follow recommendations that would improve him so he can go back to work. He has a significant loss of ability to function independently resulting from the chronic pain, both physical and behavioral, and there are no reported contraindications in the records available for review that have not been discussed with the patient. Therefore, the current request is deemed medically reasonable and necessary, per ODG criteria. A ten day trial is appropriate, with ten more to follow if patient is responding appropriately. Patient is not currently at clinical MMI, but should be before discontinuation of the program.

ODG recommends CPMP for this type of patient, and ODG supports using the BDI and BAI, among other tests, to establish baselines for treatment. Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 2001.

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

- ACOEM-AMERICA 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 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)