



Notice of Independent Review Decision

DATE OF REVIEW: 6/2/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for chronic pain management, 80 hours.

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 chronic pain management, 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Enclosed Document/Letter dated 5/14/09.
- Texas Department of Insurance Fax Cover Sheet dated 5/13/09.
- Notice to CompPartners, Inc. of Case Assignment dated 5/13/09.
- Patient Background Information/Letter dated 5/13/09.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) Form dated 5/12/09.
- Request for a Review by an Independent Review Organization Form dated 5/7/09.
- Weekly Progress Report dated 5/8/09, 5/1/09, 4/24/09, 12/26/08, 11/3/08, 10/24/08, 10/21/08, 10/17/08, 10/10/08, 9/12/08, 9/9/08, 9/5/08.
- Preauthorization History Report dated 5/7/09, 5/1/09.
- Reconsideration Request/Letter dated 5/4/09, 11/3/08.
- Patient Information Sheet dated 4/29/09, (2)(unspecified date).
- Authorization Request/Letter dated 4/29/09, 10/20/08.
- Appeal Decision Hearing Sheet dated 4/10/09.
- Notice of Independent Review Decision Report dated 12/12/08.
- Review Outcome Summary dated 12/9/08.
- Medical Certification Form dated 11/5/08
- Treatment Plan Summary dated 9/17/08.
- History of Present Illness Summary dated 10/15/08, 8/27/08.
- Preauthorization Request/Letter dated 9/17/08.
- Treatment Follow-Up Summary dated 9/9/08.
- Functional Capacity Evaluation Summary (unspecified date).
- Behavioral Health Assessment Summary dated 8/27/08.
- Review of Medical History and Physical Exam Report dated 7/21/08.
- Report of Medical Evaluation dated 7/21/08.
- Report of Medical Evaluation Form (2) dated 7/21/08.
- Patient Improvement Findings/Letter dated 7/14/08.
- Notice of Disputed and Refusal to Pay Benefits Report dated 6/13/08.
- Narrative Progress Note dated 6/19/08, 5/27/08, 4/29/08.
- Peer Review Opinion Summary dated 5/29/09.
- Texas Workers' Compensation Work Status Report dated 8/15/08, 6/17/08, 6/5/08, 5/27/08, 5/16/08, 4/29/08, 4/22/08, 4/15/08, 8/14/06, 3/20/08, 3/1/08, (unspecified date).
- MRI of Lumbar Spine Exam Report dated 4/17/08.
- History and Physical Narrative Report dated 4/15/08.
- Employers First Report of Injury or Illness Sheet xx/xx/xx.
- Radiology Report Sheet dated 3/14/08.
- Independent Review Organization Summary dated 3/14/08.
- Extended Chart Note dated 3/14/08.
- Worker's Compensation Request for Medical Care Sheet dated 3/14/08.
- Problem/Medication List dated 3/14/08.
- Electrodiagnostic Referral Request Sheet dated 3/14/08.
- Impairment Evaluation Worksheet dated 10/17/06.
- Prescription dated 8/14/06.
- Medical Contested Case Hearing Order Report (unspecified date).
- Associate Statement Sheet (unspecified date).
- Chronic Pain Management Program Description Summary (unspecified date).

- Multidisciplinary bio-psycho-social rehabilitation for chronic low-back pain description summary (unspecified date).
- Chronic Pain Program description summary (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Pulling/lifting type injury.

Diagnosis: Lumbosacral sprain/strain, low back pain, chronic pain syndrome.

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

The patient is a female who sustained a work-related injury on xx/xx/xx, involving the lumbar spine secondary to a pulling/lifting type mechanism. The patient's current diagnoses were lumbosacral sprain/strain, low back pain, and chronic pain syndrome. Of note, this patient had a previous Workers' Compensation injury, which was diagnosed as lumbar sprain/strain documented on May 16, 2006. A 0% whole-person impairment rating was filed on that injury. Subsequent to the injury in xxxx, radiographic imaging studies, i.e., a lumbar MRI did not reveal any significant changes from the previously performed lumbar MRI in 2006. The claimant underwent a designated doctor evaluation performed in July 2008, which assigned a 0% whole-person impairment rating and identified positive Waddell's signs. This report indicated the patient's complaints and symptoms of the lumbosacral spine had no significant clinical findings. Following this, the claimant's treating physician indicated that this patient's predominant issues are psychosocial. Recommendation for six individual psychotherapy sessions was provided with biofeedback. Of note, documentation indicated "no motivation to return to work demonstrated." The treating physician then requested for 20 sessions of chronic pain management program, which were reportedly approved via peer review. The patient completed the approved sessions and reportedly did not return to work. Psychosocial testing demonstrated a 3-point decrease in depression, 50% decrease in Pain Questionnaire (pain perception) and an increase in pain analog scale of 2 points. Reportedly, there was no progress toward narcotic detoxification. After review of the information submitted, the extent of this claimant's injury was lumbosacral sprain. The stated goals relating to chronic pain management are "coping" and "control of diagnosed emotional and behavioral sequelae of the pain problem are not empirically supportable. This focus is specifically proscribed in this type of patient because such a strategy "may reinforce psychological, environmental, and psychosocial factors" that promotes "chronic pain states." From the information submitted, there does not appear to be sufficient reason to overturn the prior adverse determination. The request does not present any acute medical

problem, clinical limitation, or evidence of modified treatment plan for addressing an unusual issue that would justify the extending this claimant's chronic pain management program beyond 20 sessions. This is in accordance with the Official Disability 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.
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines, Treatment Index, 7th Edition (Web), 2009, Pain—Chronic pain program.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.

- 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).