



**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 09/09/09

**IRO CASE #:**

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

Ten Session of Chronic Pain Management Program

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

Board Certified in Physical Medicine & Rehabilitation

**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.

Ten Sessions of Chronic Pain Management Program - UPHELD

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Employer's First Report of Injury or Illness,
- Patient Information Form, 04/04/07
- Health History, 04/04/07
- Initial Consultation, 04/04/07
- X-rays of the Lumbar Spine, M.D., 04/04/07
- X-rays of the Right Hip, Dr. 04/04/07
- Follow up Visit, 04/10/07
- Initial Medical Report, D.C., 04/19/07
- MRI of the Lumbar Spine, M.D., 04/30/07
- Initial Visit Comprehensive Evaluation, M.D., 05/14/07
- EMG/NCV, M.D., 05/30/07
- Designated Doctor Evaluation, M.D., 06/13/07, 10/17/07
- Follow Up Medical Report, Dr. D.C., 05/03/07, 06/19/07, 07/17/07, 08/01/07, 08/17/07, 08/24/07, 11/07/07, 11/29/07, 07/17/09
- Evaluation, Spine & Rehabilitation Center, 05/31/07, 06/01/07
- Functional Abilities Evaluation, M.D., 06/15/07
- Designated Doctor Evaluation Review, M.D., 06/28/07
- Operative Report, M.D., 07/10/07
- Required Medical Evaluation, M.D., 08/06/07
- Operative Report, Dr. 08/21/07
- Designated Doctor Evaluation Addendum, Dr. 08/30/07, 12/20/07
- Mental Health Evaluation, 09/27/07, 07/14/09
- Letter of Clarification, Dr., 11/07/07
- Pre-Authorization Request, M.D., 07/22/09, 07/23/09
- Denial Letter, , 07/29/09, 08/10/09
- Request for Reconsideration, Dr., 07/31/09, 08/03/09
- Peer Review, M.D., 08/17/09
- Letter of Medical Necessity, Dr., 08/24/09
- The ODG Guidelines were not provided by the carrier or the URA.

## **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient sustained an injury to the lumbar, hip/thigh and shoulder while lifting boxes. She had undergone x-rays at the time of the injury, as well as an MRI of the lumbar spine. She also underwent a Functional Capacity Evaluation (FCE), EMG/NCV and multiple Designated Doctor Evaluations (DDE's). Two lumbar transforaminal epidural blocks were performed. She also underwent multiple mental health evaluations. Her most recent medications were reported to be Mobic 7.5 mg, Darvocet N 100 mg, Xanax 4 m and Zoloft 50 mg.

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

Based upon the extensive medical records presently available for review, Official Disability Guidelines would not support a medical necessity for treatment in the form of a comprehensive pain management program with respect to the work injury of xx/xx/xx.

Based upon the records available for review, the above-noted reference would not support treatment in the form of a comprehensive pain management program for the following reasons:

A. The records available for review document that the patient was employed for only one day prior to sustaining an injury in the workplace. Official Disability Guidelines do indicate that such a situation would be considered a poor indicator of a successful outcome with respect to treatment in the form of a comprehensive pain management program. Additionally, given the fact that the patient is more than two years removed from the date of injury, the prognosis for a positive outcome for treatment in the form of a comprehensive pain management program would be considered to be extremely poor.

B. The records available for review do not provide any documentation to indicate there was a definitive injury sustained to the physical structure of the body with respect to the work injury of xx/xx/xx. A lumbar MRI scan obtained on 04/30/07 described findings consistent with disc protrusions at multiple levels in the lumbar spine, but the study did not appear to indicate the presence of a definitive acute pathological process to be present on this objective diagnostic assessment. Additionally, the records available for review do not provide documentation indicating there were definitive, consistent, neurological deficits on physical examination.

C. When a Designated Doctor Evaluation was conducted on 06/13/07, it was documented that there were eight of eight positive tests for Waddell's testing, indicative of symptom magnification. Additionally, when a Functional Capacity Evaluation was accomplished on 06/15/07, it was noted that the study was not a balanced study. These described findings would be considered to be a poor predictor per Official Disability Guidelines with respect to an individual deriving positive benefit from treatment in the form of a comprehensive pain management program.

D. The records available for review do document that previously the patient did receive access to ten sessions of a comprehensive pain management program. This history was noted in a mental health evaluation performed on 07/14/09. It would appear that despite receiving treatment in the form of ten sessions of a comprehensive pain management program in the past, the patient was still documented to be with significant functional deficits and difficulty with respect to pain management coping strategies. It would not appear there was a positive response to a previous attempt at treatment in the form of a comprehensive pain management program. Hence, with such documentation, Official Disability Guidelines would not appear to be supportive of consideration of treatment in the form of a comprehensive pain management program.

Extensive medical records were reviewed. The records available for review do document that the patient previously received access to ten sessions of treatment in the form of a comprehensive pain management program. It would not appear that such treatment in the past significantly enhanced the patient's functional capabilities and/or significantly assisted the claimant with respect to pain management coping strategies. Hence, per criteria set forth by Official Disability Guidelines, presently medical necessity for treatment in the form of a comprehensive pain management program would not appear to be established.

**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**
- 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)**