

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 Days in a Chronic Pain Management Program

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in 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

Adverse Determination Letters, Management Services, LLC, 1/14/10, 2/4/10
1/8/10, 12/2/09, 5/26/09
Imaging Center 1/6/08
7/6/07, 10/14/07
Orthopaedic Surgery Center 4/14/08
M.D. 11/13/09
Pain and Health 6/19/09, 4/24/09, 8/5/09
Inc. 11/5/09
Universal Rehab Center 3/9/09, 8/18/09
Dr. D.C. 8/3/09, 9/1/09
FCE 7/21/09
MRloA 1/14/10, 2/3/10

PATIENT CLINICAL HISTORY SUMMARY

This is a injured at work on x/x/xx. He fell and injured his knee and his back. He was found to have a medial and lateral right meniscal tear and a partial ACL tear on the MRI in 2008. He underwent a meniscectomy and a repair of a chondral deficit. The ACL was described as being intact during the operation in 4/14/08.

Thoracic and lumbar MRIs on 1/6/08 showed an old 50% T12 compression fracture. There were disc protrusions and foraminal compromise with bilateral root compression at L3/4 and L4/5 on the MRI (1/6/08). An EMG performed 3/9/09 reportedly showed abnormalities in the right medial gastrocnemius, but there were "softer" polyphasic findings in other muscles.

He continued to have back pain going to the right lower extremity. He had a lumbar ESI on 4/24/09 with limited benefit. He had an intrarticular knee corticosteroid injection on 6/19/09. This reportedly helped, but he remained depressed.

Records indicate the patient was depressed. He was started on Prozac. His pain screening described his BDI as 26 and his BAI as 25. Ms. felt that this may be due to some misunderstanding of the questions. A request for a pain program to help with coping skills and an adjustment disorder was made. He is on Darvocet for pain.

The FCE (11/5/09) showed him to be at a sedentary work level. He was limited in testing because of the back pain. The the pain was localized to the right knee and lumbar region (Universal Rehab Center 8/18/09). The pain did not appear to be radicular.

Dr. and Dr. recommended lumbar surgery, an L5/S1 discectomy. The patient did not want to proceed.

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

The patient is now more than 24 months post injury. According to the ODG, "there is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months)."

Ms. and Dr. describe depression, lack of coping, and the patient's mood, but not his motivation to improve. There is no discussion in the records of the vocational issues involving this patient other than Dr. stating he would need vocational retraining in the pain program. This does not satisfy ODG criteria calling for addressing negative predictors of efficacy of treatment. It is unclear if the patient has 1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; or (3) a negative outlook about future employment.

It is also unclear from the records provided whether the claimant has had any psychological treatment other than being prescribed Prozac. Criteria 2 of the ODG states there should be no other treatment options left to offer. While the pain program could be justified to avoid the surgical option, it is unclear if all psychological interventions addressing the issues described have been pursued. For these reasons, the patient does not satisfy the ODG criteria for participation in a chronic pain program (functional restoration program). The reviewer finds that medical necessity does not exist at this time for 10 Days in a Chronic Pain Management Program.

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