

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 5/10/2010  
**IRO CASE #:**

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

Chronic Pain Program (10 Days)

**QUALIFICATIONS OF THE REVIEWER:**

Neurosurgery, Neurosurgery Pediatric, Surgery Spine

**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)

Chronic Pain Program (10 Days) Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Carrier submission by dated 04/23/2010
2. Reviews of case assignment by dated 04/20/2010
3. Request form by author unknown dated 04/14/2010
4. Letter by DO dated 03/26/2010
5. Notice of determination by MD dated 03/10/2010
6. Review by an IRO by author unknown dated unknown.
7. Low back lumbar & thoracic dated unknown.
8. Integrated treatment/Disability duration guidelines dated unknown.
9. Reviews of case assignment by dated 04/20/2010rev
10. Request form by author unknown dated 04/14/2010
11. Letter by DO dated 03/26/2010
12. Notice of determination by MD dated 03/10/2010
13. Review by an IRO by author unknown dated unknown

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is male with a date of injury xx/xx/xx, when he was moving an ice box up some stairs. He is status post L4-L5 fusion in 1989. He is status post right L2-L3 and L3-L4 laminectomy on the right on 07/28/2009. His symptoms did not improve after surgery. He complains of low back pain and bilateral leg pain. He has gone through physical therapy. Facet blocks at L2-L3 and L3-L4 on 12/01/2009 did not help. His neurological examination reveals an absent right patellar reflex and trace bilateral iliopsoas weakness. Electrophysiologic studies 10/13/2009

of the right lower extremity were unremarkable. A CT myelogram 09/09/2009 showed advanced disc degeneration at L2-L3 and L3-L4 with retrolisthesis at both levels. His medications include Pamelor, hydrocodone, and methocarbamol. A psychological evaluation on 03/04/2010 diagnosed him with a chronic pain syndrome. His Beck Depression inventory and Beck Anxiety inventory scores are both in the severe range. An FCE (functional capacity evaluation) 02/24/200 showed him currently at a sedentary/light physical demand level. It is documented that he has undergone 3 sessions of recent physical therapy. No other postoperative physical therapy notes are submitted for review. The provider is requesting pain management, 5 times a week for 2 weeks (total of 10 sessions).

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

The 10 day chronic pain program is considered not medically necessary. According to the ODG, "Pain" chapter, "Previous methods of treating chronic pain" should "have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement".

In this case, there is documentation of three physical therapy sessions after the surgery of 07/8/2009. It is, therefore, unclear that the injured employee has exhausted all treatment options for managing his pain condition. Also, there are significant anxiety and depression issues that may need to be addressed by individual psychotherapy sessions, in order to optimize his overall functioning. Therefore, based on the submitted documentation, the 10-day chronic pain program is considered not medically necessary. The recommendation is to uphold the previous denial.

**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)

ODG Treatment - Integrated Treatment/Disability Duration Guidelines - Low Back - Lumbar & Thoracic (Acute & Chronic)

ODG Treatment - Integrated Treatment/Disability Duration Guidelines - Pain (Chronic)