



**Notice of Independent Review Decision  
IRO REVIEWER REPORT – WC (Non-Network)**

**DATE OF REVIEW:** 10/01/10

**IRO CASE #:**

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

Chronic Pain Management 10 Days

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

Board Certified in Orthopedic Surgery

**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.

Chronic Pain Management 10 Days - OVERTURNED

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- CT Lumbar Spine, M.D., 06/18/99
- Lumbar Myelogram, M.D., 09/09/99
- Operative Report, Medical Imaging, 01/31/02
- Lumbar Myelogram, M.D., 03/10/05
- Postmyelogram Lumbar CT, Dr., 03/10/05
- History and Physical, M.D., 06/08/05
- Report of Procedure, Dr., 06/08/05
- Chest CT, M.D., 06/17/05
- Office Notes, Dr., 09/18/07, 02/29/08, 07/15/08, 02/17/09, 07/13/09, 12/01/09, 04/13/10
- Request for Chronic Pain Management Program, 08/18/10
- Letter of Medical Necessity, Dr., 08/18/10
- Pre-Authorization Modified Approval Form, Health Services, 08/24/10
- Physical Performance Evaluation, Health Services, 08/24/10
- Psychosocial Evaluation, Health Services, 08/24/10
- Patient Assessment, Health Services, 08/24/10

- Pre-Authorization Request, Health Services, 08/25/10, 08/30/10
- Letter of Appeal, Dr., 08/30/10, 09/09/10
- Denial Letter, 08/30/10
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

A CT lumbar spine showed slight narrowing of the spinal canal at L4-L5 in respect to the L3 level, as well as mild hypertrophy of the facets at L4 and L5 bilaterally. There was also mild narrowing of the left L4 neural foramina as compared to the right, probably secondary to the hypertrophic osseous structure from the inferior facet. A lumbar myelogram showed subtle irregularity of the proximal left L5 dural nerve root sleeve, with adequate peripheral filling and wide posterior decompressive laminectomies were present at L4-L5 and L5-S1 with bilateral posterolateral osseous fusions from L4 to S1. The fusions appeared fragmented, particularly on the right. Translaminar injection of steroids at L3-L4 was performed. A postmyelogram lumbar CT showed status post laminectomies at the L4-L5 and L5-S1 levels, bilateral posterolateral spinal fusion procedures at L4-L5 and L5-S1 and an interbody spinal fusion at L4-L5. There was marked central canal stenosis at the L3-L4 level secondary to hypertrophy of the posterior elements, ligamentum flava and diffuse circumferential annular disc bulging. The patient then underwent a re-do decompressive bilateral lumbar laminectomy at L4-L5 and L5-S1, bilateral foraminotomies at L4-L5 and L5-S1 with exploration disc space at L4-L5 and L5-S1, as well as an additional bilateral central decompressive lumbar laminectomy at L3-L4 with excision of central disc herniation at L3-L4. A chest CT was performed which was negative. The claimant was treated with Soma and Lyrica following the surgery, as well as utilizing a back and neck brace. She was unable to work and a chronic pain management program was requested.

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

After a review of the medical records, I recommend for certification of ten days of chronic pain management. The medical records do appear to more than adequately document that the patient qualifies for a chronic pain management program within Official Disability Guidelines (ODG) criteria as listed below. There has also been adequate documentation of the goals presented for the patient and these fall within Official Disability Guidelines criteria. Therefore, I do feel the claimant is a candidate for ten days of a chronic pain management program with a multidisciplinary approach that includes orthopedics, pain management, physical medicine and rehabilitation, psychology, and physical therapy.

**Criteria for the general use of multidisciplinary pain management programs:**

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e)

Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

**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)
- AMA GUIDES 5<sup>TH</sup> EDITION