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# Notice of Independent Review Decision

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

**DATE OF REVIEW:** 02/10/11

**IRO CASE #:**

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

Ten sessions of a chronic pain management program for two weeks

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

Licensed by the Texas State Board of Psychological Examiners

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

**X** 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 a chronic pain management program for two weeks - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with Dr dated 02/20/08, 02/29/08, and 12/20/10
MRIs of the lumbar spine, cervical spine, and left shoulder interpreted by M.D. dated 03/03/08

Evaluations with Dr. dated 03/11/08, 03/27/08, 04/10/08, 05/12/08, 07/08/08, 08/07/08, 09/22/08, 10/21/08, 12/01/08, 03/11/09, 04/13/09, 05/19/09, 06/18/09, 07/09/09, and 09/17/09
An EMG/NCV study interpreted by M.D., Ph.D. dated 03/20/08
Evaluations with M.D. dated 04/08/08, 06/06/08, and 09/15/08
An operative report from Dr. dated 06/11/08
Evaluations with Dr. dated 07/28/08, 01/30/09, 06/25/09, 01/05/10, 04/19/10, 05/03/10, 05/10/10, 06/14/10, and 09/29/10
Evaluations with M.D. dated 10/10/08, 10/24/08, 11/07/08, 11/14/08, 12/05/08, 01/09/09, 01/23/09, 03/20/09, 04/30/09, 05/29/09, 07/24/09, and 09/11/09
An operative/procedure report from Dr. dated 11/03/08
Prescriptions for physical therapy from Dr. dated 11/07/08, 11/14/08, and 01/09/09
A prescription from Dr. dated 11/24/08
A radiographic report from Dr. dated 03/25/09
A CT scan of the lumbar spine interpreted by M.D. dated 06/19/09
X-rays of the lumbar spine interpreted by Dr. dated 06/19/09
Evaluations with M.D. dated 10/20/09 and 12/05/09
A lumbar epidural steroid injection (ESI) with Dr. dated 11/07/09
An appeal for reconsideration from Ph.D. dated 12/28/09
A lumbar surgery with Dr. dated 04/21/10
A radiographic report from Dr. dated 06/24/10
An evaluation with M.D. dated 08/26/10
A Physical Performance Evaluation (PPE) with an unknown provider (no name or signature was available) dated 11/09/10
X-rays of the lumbar spine interpreted by M.D. dated 11/11/10
An evaluation with Dr. dated 11/16/10
A rehabilitative evaluation with P.T. dated 11/29/10
A chronic pain management evaluation with Dr. dated 12/03/10
An interdisciplinary team conference with Dr., Mr., and Dr. dated 12/20/10
A preauthorization request for chronic pain management from Dr. dated 12/20/10
A letter of non-authorization for chronic pain management, according to the Official Disability Guidelines (ODG) from Ph.D., dated 12/22/10

Letters of non-authorization for chronic pain management, according to the ODG, dated 12/22/10 and 01/04/11
A letter of non-authorization for chronic pain management, according to the ODG, from Ph.D. dated 01/03/11
The ODG Guidelines were not provided by the carrier or the URA

**PATIENT CLINICAL HISTORY**

On 02/20/08, Dr. recommended an MRI, Vicodin, Prednisone, and Flexeril. On 02/29/08, Dr. recommended continued therapy, an MRI, and Naprosyn. An MRI of the lumbar spine interpreted by Dr. on 03/03/08 showed facet arthrosis throughout, a small synovial cyst at L3-L4, desiccation at L2 through L5, reactive endplate edema at L4-L5, a Modic's sign at L3-L4, disc protrusions/extrusions at L2-L3 and L4-L5, a mild bulge at L5-S1, and 1-2 mm. eccentric bulges at L3-L4. An MRI of the cervical spine interpreted by Dr. on 03/03/08 showed fairly significant disc protrusions at C5-C6 and C6-C7, disc desiccation throughout, periligamentous edema from the base of the skull through C3, and a small bulge at C2-C3 and C3-C4. An MRI of the left shoulder interpreted by Dr. on 03/03/08 showed a type II-III acromion with capsular hypertrophy of the AC joint, arthritic changes of the AC joint proper, subacromial bursitis, and tendinosis/tendinopathy. On 03/11/08, Dr. recommended Xodol, Celebrex, Flexeril, and physical rehabilitation. An EMG/NCV study interpreted by Dr. on 03/20/08 showed mild to moderate bilateral carpal tunnel syndrome and moderate axonal and demyelinating peripheral neuropathy. On 06/11/08, Dr. performed an anterior cervical discectomy and osteophytectomy at C5-C6 and C6-C7, an anterior interbody arthrodesis, and application of intervertebral cages, and anterior cervical instrumentation at C5-C6 and C6-C7. On 08/07/08, Dr. recommended a psychological evaluation for possible spinal cord stimulation. On 09/15/08, Dr. recommended further rehabilitation, cervical x-rays, and OxyContin. On 11/03/08, Dr. performed a left shoulder rotator cuff repair, an arthroscopic shoulder debridement, and an acromioplasty. Lunesta was refilled by Dr. on 03/11/09. On 03/25/09, a radiographic report from Dr. showed surgical artifacts at C5, C6, and C7 and decreased disc space at C4-C5. On 05/19/09, Dr. recommended a lumbar myelogram CT scan. A CT scan and x-rays of the lumbar spine interpreted by Dr. on 06/19/09 showed multiple extradural defects along the ventral thecal sac, probably related to disc bulges and protrusions, which were most prominent at L4-L5. L1-L2 and L2-L3 retrolisthesis was also noted.
On07/09/09,Dr. recommended lumbar spine surgery. A lumbar ESI was performed by Dr. on 11/07/09. On 12/28/09, Dr. wrote an appeal for reconsideration of the pain management program. On 01/05/10, Dr. recommended lumbar surgery. On 04/21/10, Dr. performed an anterior interbody arthrodesis, application of an intervertebral cage, and an anterior partial corpectomy at L4-L5. On 08/26/10, Dr. changed Oxycontin to Opana ER and recommended a home exercise program. On 11/09/10, a chronic pain

management program was requested. X-rays of the lumbar spine interpreted by Dr. on 11/11/10 showed only operative changes at L4-L5. On 11/16/10, Dr. recommended a return to work program. On 11/29/10, Mr. recommended 10 sessions of a chronic pain management program. On 12/03/10, Dr. requested 20 sessions of a chronic pain management program. On 12/20/10, Dr. wrote a preauthorization request for 10 sessions of a chronic pain management program. On 12/22/10 and 01/04/11, provider wrote letters of non-authorization for 10 sessions of chronic pain management.

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

The ODG Guidelines (Chapter on Treating Pain) regarding treatment specifically notes that when a disability has persisted for more than 24 months, research studies have not been able to consistently demonstrate that such treatment, including a chronic pain management program, produces the ability to return to work. Additionally, the ODG does not support repeating or enrolling in a similar rehabilitation program and it appeared in the records that the patient had participated in a work hardening program previously. The DSM IV diagnosis of 307.89 (Pain Disorder Associated with both psychological factors and a general medical condition) is questionable for this patient. The psychological tests administered did not reveal abnormal levels of either depression or anxiety or any other mental health condition. In the records provided for review, the persistence of pain was supported through a variety of evaluations and tests; however, no specific psychological factors were identified or discussed in the narrative that would indicate that psychological factors were causing, exacerbating, or sustaining the pain reported by the patient. Therefore, the requested 10 sessions of a chronic pain management program would not be reasonable or necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE**
- ☐ **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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)