



Specialty Independent Review Organization, Inc.

January 31, 2006

DWC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient: \_\_\_\_  
DWC #: \_\_\_\_  
MDR Tracking #: M2-06-0509-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor with a specialty in Anesthesia and Pain Management. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

The patient was injured on \_\_\_\_ while attempting to pick up a heavy welding machine (approximately 100 lbs) and had back and neck pain. The patient states he felt a pop in his neck at the time of accident. At the time of injury, he described the pain as sharp and stabbing. The patient presented to Dr. Day, who placed him on light duty and prescribed medications. A week or so later, he presented to Shamrock Emergency Medical Clinic. He was prescribed therapy. He presented to Dr. Day a short time later and asked to be removed from work. Dr. Day prescribed physical therapy. He changed doctors to Robert LeGrand. Pain management injections were performed with limited relief of symptoms. He was referred to Concho Valley Rehab.

The patient underwent a discectomy and fusion on 2/9/05. He has completed a work hardening program.

#### RECORDS REVIEWED

##### General Records

- IRO assignment
- Preauth denial of 10/31/05
- Reconsideration request 11/17/05
- Letter from Dr. Shaugnessy

##### Records from the Carrier:

- 1/10/06 carrier letter
- Report of Medical Evaluation by Dr. Shaugnessy
- FCE of 10/3/05

##### Records from the Doctor:

- Office notes by Dr. Shaugnessy from 03/17/05 through 12/30/05
- Office notes by Dr. Tony Smith 3/17/05
- Concho Valley progress notes from 4/18/05 through 12/29/05
- FCE's of 5/9/05, 6/3/05 and 12/14/05
- Concho Valley rehab notes of 7/29/05 and 10/3/05
- Psychological eval report 6/21/05
- Clinical interview of 12/29/05

#### REQUESTED SERVICE

The requested service is a 5x per week for four weeks chronic pain management program.

#### DECISION

The reviewer disagrees with the previous adverse determination.

#### BASIS FOR THE DECISION

The reviewer notes it is the providers' responsibility to establish medical necessity for a particular medical service. The reviewer notes that the provider has met this responsibility in this case. The patient could primarily benefit from the psychological portion of this program. He has undergone all avenues of conservative treatment and is post operative by 11 months. There is no evidence of malingering and his symptomatic complaints seem genuine and directly related to the work injury. He continues to present pain behavior in regards to adjustment to ADL's as well as persistent depression and anxiety.

The patient has had a minimal response in several areas and this program will be instrumental in targeting his depression and anxiety further. The patient's physical limitations have decreased due to completion of his WH program; however, his psychological symptoms persist.

In terms of established guidelines, the AAPM does recognize the medical necessity for this type of treatment within various parameters. This patient meets criteria for the following: disrupted ADL's due to emotional dysfunction, perceived permanent loss of functioning, mental impairment has exceeded expectations and response to the mental health treatment has continued beyond expected time frame.

The reviewer feels that this type of program will enhance his post-operative recovery. The reviewer notes that he presents with psychosocial symptoms that need to be addressed further. This program should be able to reduce the patient's dependence on narcotic pain medications and instruct the patient on appropriate usage of non-narcotic analgesics. The primary source of the patient's anxiety is related to the perceived inability to return to normal duties. The patient presents with a self image of disability.

#### REFERENCES

Albright et al Philadelphia Panel Evidence based Clinical Practice Guidelines on Selected Rehabilitation Interventions for low back pain. Physical Therapy. 81(10). Oct. 2001.

American Academy of Pain Management Guidelines

Workman EA, et al Co morbid psychiatric disorders and predictors of pain management program success in patients with chronic pain. Aug 2002 4(4) p. 137-40.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Sincerely,

Wendy Perelli, CEO

**Your Right To Appeal**

**If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.**

**If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.**

Sincerely,

Wendy Perelli, CEO

**I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the Division via facsimile, U.S. Postal Service or both on this 31<sup>st</sup> day of January 2006**

**Signature of Specialty IRO Representative:**

**Name of Specialty IRO Representative: Wendy Perelli**