

November 6, 2006

TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_

EMPLOYEE: \_\_\_

POLICY: M2-07-0055-01

CLIENT TRACKING NUMBER: M2-07-0055-01/5278

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Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing 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.

**Records Received:**

Records from the State:

Notification of IRO Assignment, 10/2/06

IRO Assignment Letter, 10/2/06

Medical Dispute Resolution Request/Response, 9/7/06

Provider List

Table of Disputed Services

2875 S. Decker Lake Drive Salt Lake City, UT 84119 / PO Box 25547 Salt Lake City, UT 84125-0547

(801) 261-3003 (800) 654-2422 FAX (801) 261-3189

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Denial letters 8/21/06, 8/30/06

Records from the Respondent:

Response letter to MDR request 9/29/06  
Response to 7-day letter, 10/9/06  
Report of MRI of the lumbar spine, 2/7/06  
Functional Abilities Evaluation, 4/10/06  
Report of RME, 4/10/06  
TWCC Work Status Report, 4/10/06  
Notice of disputed issues and refusal to pay benefits, 4/19/06

Records from the Requestor:

Electrodiagnostic evaluation, 3/28/06  
Mental Health Evaluation Update, 8/14/06  
Pre-Authorization Request, 8/15/06  
Request for Reconsideration, 8/22/06  
Letter of medical Necessity, 10/17/06

**Summary of Treatment/Case History:**

The claimant is a 43 year-old gentleman who allegedly suffered a workplace injury on \_\_\_\_\_. Subsequently he developed low back pain that radiates to the right leg. He has undergone conservative treatment including physical therapy and medications. Physical examination reveals positive straight leg raising test at 10 degrees supine and 45 degrees sitting. MRI examination of the lumbar spine reveals widespread degenerative disc disease and an EMG reveals signs of right L5 radiculopathy.

**Questions for Review:**

Items in dispute: Pre-authorization request: Chronic Pain Management program 20 sessions (#97799-CP) – review for medical necessity.

**Explanation of Findings:**

The claimant appears to satisfy the usual selection criteria for entry into a multidisciplinary chronic pain management program as listed below. Furthermore, the ACOEM guidelines state that: “Research suggests that multidisciplinary pain care is beneficial for most persons with chronic pain, and likely would be considered the treatment of choice for persons who are at risk for, or who have, chronic pain and disability.” (Chapter 6, Page 114) Therefore the proposed 20 sessions of chronic pain management should be considered to be medically necessary.

### **Conclusion/Decision to Certify:**

Items in dispute: Pre-authorization request: Chronic Pain Management program 20 sessions (#97799-CP) – review for medical necessity.

The proposed 20-session chronic pain management program is medically necessary.

### **Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:**

The usual selection criteria for entry into a chronic pain management program are:

1. Referral for entry has been made by the primary care physician/attending physician; and
2. Patient has experienced chronic non-malignant pain (not cancer pain) for 6 months or more; and
3. The cause of the patient's pain is unknown or attributable to a physical cause, i.e., not purely psychogenic in origin; and
4. Patient has failed conventional methods of treatment; and
5. The patient has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated; and
6. Patient's work or lifestyle has been significantly impaired due to chronic pain; and
7. If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into the pain program.

### **References Used in Support of Decision:**

McAllister M. et al. (2005). Effectiveness of a Multidisciplinary Chronic Pain Program for Treatment of refractory Patients with Complicated Chronic Pain Syndromes. *Pain Physician* 8: 369-73.

Patrick, et al. (2004). Long-term outcomes in multidisciplinary treatment of chronic low back pain: results of a 13-year follow-up. *Spine* 29: 850-5.

Skouen, et al. (2002). Relative cost-effectiveness of extensive and light multidisciplinary treatment programs versus treatment as usual for patients with chronic low back pain on long-term sick leave: randomized controlled study. *Spine* 27: 901-9; discussion 909-10.

Haldorsen, et al. (2002). Is there a right treatment for a particular patient group? Comparison of ordinary treatment, light multidisciplinary treatment, and extensive multidisciplinary treatment for long-term sick-listed employees with musculoskeletal pain. *Pain* 95: 49-63.

Guzman, et al. (2002). Multidisciplinary bio-psycho-social rehabilitation for chronic low back pain. *Cochrane Database Syst Rev* CD000963.

Turk (2001). Combining somatic and psychosocial treatment for chronic pain patients: perhaps 1 +

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Flor, et al. (1992). Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. Pain 49: 221-30.

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The physician providing this review is board certified in Anesthesiology. The reviewer holds additional certification in Pain Medicine from the American Board of Pain Medicine. The reviewer is a diplomate of the National Board of Medical Examiners. The reviewer has served as a research associate in the department of physics at MIT. The reviewer has received his PhD in Physics from MIT. The reviewer is currently the chief of Anesthesiology at a local hospital and is the co-chairman of Anesthesiology at another area hospital. The reviewer has been in active practice since 1978.

### 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.

Chief Clerk of Proceedings /  
Appeals Clerk  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 6 day of Nov/2006.

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Valerie Ottman

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Valerie O ext 554

Cc: Requestor  
Respondent