



## CompPartners Final Report



CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:** \_\_\_\_\_  
**Texas IRO # :** \_\_\_\_\_  
**MDR #:** M2-07-0110-01  
**Social Security #:** \_\_\_\_\_  
**Treating Provider:** Carlos Viesca, MD  
**Review:** Chart  
**State:** TX  
**Date Completed:**

### **Review Data:**

- **Notification of IRO Assignment dated 10/10/06, 1 page.**
- **Receipt of Request dated 10/10/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 9/12/06, 2 pages.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Case Review dated 8/22/06, 8/4/06, 5/24/06, 6 pages.**
- **Legal Letter dated 11/7/06, 2 pages.**
- **Pre-Authorization Determination dated 8/23/06, 8/7/06, 4 pages.**
- **Medical Record Review dated 6/30/06, 3/9/06, 9 pages.**
- **Letter dated 3/17/06, 3/13/06, 3/9/06, 10/7/04, 9/22/04, 23 pages.**
- **Operative Report dated 11/3/05, 2 pages.**
- **Left Shoulder MRI dated 3/2/05, 1 page.**
- **Medical Review dated 10/6/04, 5 pages.**
- **Lumbar Spine MRI dated 3/2/05, 2 pages.**
- **Physician Orders dated 5/3/06, 1 page.**
- **Subsequent Medical Report dated 7/12/06, 6/7/06, 5/3/06, 4/5/06, 3/8/06, 10 pages.**
- **Pending Review dated 5/3/06, 4 pages.**
- **SOAP Note dated 4/28/06, 4/18/06, 4 pages.**
- **Evaluation dated 6/27/06, 4/20/06, 1/31/06, 7 pages.**
- **CT Post Discogram dated 1/13/06, 1 page.**
- **Procedure Report dated 1/13/06, 3 pages.**
- **Post-operative orders and patient instructions dated 1/13/06, 1 page.**
- **Letter of Dispute dated 8/31/06, 7 pages.**
- **Letter of Appeal dated 8/9/06, 6 pages.**
- **Intake Assessment and Report dated 7/28/06, 5 pages.**
- **Physical Performance Evaluation dated 7/28/06, 5 pages.**
- **Initial Examination dated 7/28/06, 2 pages.**
- **Employee's Request to Change Treating Doctors dated 6/26/04, 1 page.**
- **Memorandum dated 6/21/06, 1 page.**
- **Physical Examination dated 6/21/06, 6 pages.**

**Reason for Assignment by TDI:** Determine the appropriateness of the previously denied request for 20 sessions chronic pain management.

**Determination:**

**PARTIAL REVERSED – 10 sessions of chronic pain management**

**PARTIAL UPHeld – 10 sessions of chronic pain management**

**Rationale:**

**Patient's age:** 52 years

**Gender:** Male

**Date of Injury:** \_\_\_\_

**Mechanism of Injury:** Fell from a moving vehicle.

**Diagnoses:**

1. Status post left shoulder surgery.
2. Chronic left shoulder pain.
3. Chronic low back pain.
4. Chronic pain management (anxiety/depression).

A review of the information submitted indicated that this patient has an accepted work injury involving the lumbar spine and left shoulder. He was evaluated after the injury and found to have a partial thickness tear in his left shoulder and a right paracentral disk extrusion with inferior extension at L5-S1 level, resulting in severe spinal canal stenosis and associated neural foraminal stenosis. Electromyogram/nerve conduction velocity (EMG/NCV) studies of the lower extremities were reportedly performed on two separate occasions, the last being on 4/20/06, by Michael Mrocheck, MD, which revealed no radiculopathy, but showed advanced peripheral neuropathy. After an initial period of conservative treatment, activity restriction, physical therapy, and medication management, this patient eventually required a surgical intervention involving the left shoulder in the form of arthroscopic debridement, open acromioplasty and rotator cuff repair with orthobiological grafting performed on 11/3/05. Pertaining to the lumbar spine, this patient underwent multiple lumbar epidural steroid injections (ESI) with marginal results. Subsequently, this patient underwent post-surgical rehabilitation, physical therapy, and activity restriction. In spite of multi-modality conservative treatments, post-operative rehabilitation, and surgical intervention, the patient continued to experience severe bouts of low back pain and left shoulder pain. He also suffered from significant anxiety and showed clinical features of reactive depression as indicated by a Beck Depression Inventory (BDI) score of 17 and a Beck Anxiety Inventory (BAI) score of 18. Reportedly, the patient remained unable to function out of work, unable to deal with stress, insomnia, and remained unable to perform activities of daily living (ADL) without discomfort. Current medications included Vicodin ES three tablets per day, Neurontin 400 mg b.i.d., Ultram 50 mg one per day, and Lexapro 20 mg one per day, all of which provide this patient with continued pain level of 7/10. This claimant review of patient's physical deficits and associated psychological issues, he requested a comprehensive pain management program in order to provide the patient with functional restoration so that he can return to gainful suitable occupation.

The patient is an appropriate candidate for a chronic pain management program for the following reasons:

1. Failure of surgical intervention.
2. Failure of multi-modality conservative treatment.
3. Significant dependence upon opioid medication.
4. Inability to maintain ADL's
5. Inability to pursue occupational abilities
6. Significant anxiety and depression with inability to deal with the chronic pain.
7. Finally, this patient requires treatment with all of appropriate measure in order to achieve a functional restoration in order to facilitate a return to being gainfully employed and his pre-injury customary occupation to include the issue of medication management and allow the provider to minimize and/or reduce the patient's dependence on narcotics.

**Criteria/Guidelines utilized:** TDI/DWC Rules and Regulations. ACOEM Guidelines, 2<sup>nd</sup> Edition, Chapter 6, which supports the use of a chronic pain management program in order to achieve functional restoration. Pain Management: A Comprehensive Review, 2<sup>nd</sup> Edition, Chapter 11, edited by P. Prithvi Raj, M.D. Article entitled, "Coexisting Psychological Factors," by Peleg, et al, in Practical Pain Management; September/October 2004, Volume, Issue 5, which also addresses the importance of functional restoration programs in order to achieve functional improvement.

**Physician Reviewers Specialty:** Pain Management/Anesthesiology

**Physician Reviewers Qualifications:** Texas Licensed M.D.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.**

#### 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.

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Date: 1/23/2007

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, requestor, claimant and the Division via facsimile or U.S. Postal Service from the office of the IRO on this \_\_\_ day of \_\_\_ 2006.

Signature of IRO Employee:

Printed Name of IRO Employee

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