

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
7502 GREENVILLE AVENUE
SUITE 600
DALLAS, TEXAS 75231
(214) 750-6110
FAX (214) 750-5825

DATE OF REVIEW: April 9, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten (10) sessions chronic behavioral pain management

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

Diplomate, American Board of Psychiatry and Neurology in Psychiatry; Diplomate, American Board of Pain Medicine; American Society of Addiction Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Insurance Company, 02/15/07, 03/06/07, 03/27/07
- D.O., 02/27/06
- M.D., 12/12/06, 01/16/07, 02/13/07

PATIENT CLINICAL HISTORY:

The patient had a commuted fracture the right first metatarsal the foot secondary to a pipe falling on it. The patient eventually proceeded to healing. Complex regional pain syndrome was reportedly diagnosed without any objective findings. The patient was

April 9, 2007

Page 2 of 5

given name 11% whole person impairment. Evaluation is inadequate to substantiate the need for interdisciplinary treatment.

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

Evidenced-based guidelines support return to work as soon as possible. This is especially true with a relatively minor foot bone fracture. Therefore, in my opinion, 10 sessions of chronic behavioral pain management are not reasonable or necessary as related to the original injury.

Official Disability Guidelines -Return to work- Stress related conditions and other Mental Disorders section

Recommended. While depressed individuals have frequently requested leave from the workplace, this is not the best way in which to help the depressed employee. It is true that a person may temporarily become impaired so that a short-term leave, such as a week or two may be required. However, there is no empirical evidence to indicate that long-term leave is beneficial to the depressed person. In fact, when looking at the research for physical concerns and injuries, a person frequently becomes depressed when unable to complete normal, everyday activities. Thus, a long-term leave may actually increase MDD symptoms, instead of decreasing them. There are several reasons for this: 1) A depressed person naturally seeks to isolate oneself from others. 2) Being on leave reinforces this isolation, instead of encouraging the person to increase social interactions; 3) Being on long-term leave causes an individual to identify with a "disabled" lifestyle; and 4) Based on the DSM-IV-TR criteria for MDD, when one is depressed, one tends to not lead a healthy lifestyles. ([Warren, 2005](#)) See ODG Capabilities & Activity Modifications for Restricted Work under "[Work](#)."

Official disability guidelines - return-to-work-pain section:

Return to work

Recommended. Expedited return-to-work has been shown to be more useful in improving function and decreasing pain than extended disability. ([Bernacki, 2000](#)) ([Boseman, 2001](#)) ([Colorado, 2002](#)) ([Melhorn, 2000](#)) Lost productive time from common pain conditions among active workers costs an estimated 61.2 billion dollars per year. The majority (76.6%) of the lost productive time was explained by reduced performance while at work and not work absence. ([Stewart, 2003](#)) Chronic pain is independently related to low self-rated health in the general population. ([Mantyselka-JAMA, 2003](#)) Significant pain improvement is seen in groups that are prescribed light activity over groups that receive only medical treatment, especially in cases involving back pain. Extended bed rest is not recommended. ([van Lankveld, 2000](#))

Return-To-Work Low Back Section ODG:

Work

Recommended as indicated below. There is strong epidemiological evidence that physical demands of work (manual materials handling, lifting, bending, twisting, and whole body vibration) can be associated with increased reports of back symptoms, aggravation of symptoms and “injuries.” While the epidemiological evidence shows that low back symptoms are commonly linked to physical demands of work, that does not necessarily mean that LBP is caused by work. Although there is strong scientific evidence that physical demands of work can cause individual attacks of LBP, overall that only accounts for a modest proportion of all LBP occurring in workers. There is moderate scientific evidence that physical demands of work play only a minor role in the development of disc degeneration. There is strong epidemiological and clinical evidence that care seeking and disability due to LBP depend more on complex individual and work-related psychosocial factors than on clinical features or physical demands of work. ([Carter, 2000](#)) ([Johanning, 2000](#)) ([Xiao, 2004](#)) Graded activity (including modified duty) is more effective than usual care in reducing the number of days of absence from work because of low back pain. ([Staal, 2004](#)) Studies of monozygotic twins show that low back aging changes are genetic with little influence of experience short of spine fracture and dislocation, or perhaps being brought on earlier with smoking. ([Ropponen, 2004](#)) ([Videman, 2003](#)) ([Battie, 2002](#)) The Activity Modifications below may be used to establish shared expectations to facilitate the transition toward return to work, but caution must be exercised that these restrictions do not reinforce the disability. One recent trial found that exercise focused on Function-Centered Treatment (FCT) did much better than exercise focused on Pain-Centered Treatment (PCT). FCT emphasized that patients should continue therapeutic activities even if their pain increased, as opposed to the PCT group who were told to stop activities when pain increased. At the onset of the study, physicians and therapists criticized the FCT because they feared that encouraging the patients to move regardless of pain would lead to an increase in pain intensity, but the pain reduction experienced by the FCT group supports the hypothesis that fear of pain may be more disabling than pain itself. When pain intensity is used to determine the intensity of the exercises, it may lead to restrictive recommendations regarding activity and work, and it seems to increase behaviors such as taking pain-killers, seeking health care, stopping work, limping, guarding, and talking about pain. ([Kool, 2005](#)) See also [Return to work](#).

ODG Capabilities & Activity Modifications for Restricted Work:

Clerical/modified work: Lifting with knees (with a straight back, no stooping) not more than 5 lbs up to 3 times/hr; squatting up to 4 times/hr; standing or walking with a 5-minute break at least every 20 minutes; sitting with a 5-minute break every 30 minutes; no extremes of extension or flexion; no extremes of twisting; no climbing ladders; driving car only up to 2 hrs/day.

April 9, 2007
Page 4 of 5

Manual work: Lifting with knees (with a straight back) not more than 25 lbs up to 15 times/hr; squatting up to 16 times/hr; standing or walking with a 10-minute break at least every 1-2 hours; sitting with a 10-minute break every 1-2 hours; extremes of flexion or extension allowed up to 12 times/hr; extremes of twisting allowed up to 16 times/hr; climbing ladders allowed up to 25 rungs 6 times/hr; driving car or light truck up to a full work day; driving heavy truck up to 4 hrs/day.

**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)