



Notice of Independent Review Decision  
**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 4/4/2008  
**IRO CASE #:**

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

1. Pain Management Program 5 x 2.

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from Parker College of Chiropractic, Dallas, TX and completed training in Chiropractor at Parker College of Chiropractic, Post-Graduate. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Chiropractor since 1986.

**REVIEW OUTCOME:**

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

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

1. Pain Management Program 5 x 2. Upheld

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This injured employee is noted to have sustained an injury at work when she was lifting a \$500 box of quarters and felt a burning/stinging pain in her neck. On the night of the injury, the injured worker took ibuprofen and used a heating pad for relief. She reported the injury and went to the emergency room on xx/xx/xx. According to a progress note dated 3/27/2006, the injured worker presented with complaints of pain from the neck radiating into the shoulder, decreased range of motion, tenderness and spasms at T1-T6, depression, and anxiety. The pain was described as burning and stabbing and is decreased with less activity, laying down, and/or taking medication.

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

This injured worker was employed as an when she lifted a \$500 box of quarters weighing 30-50 lbs and felt a burning/stinging sensation in her neck and left shoulder. She finished her shift, took ibuprofen that night and used a heating pad over the weekend. She then reported the injury to her supervisor and went to the emergency room. She told the emergency room staff that she had taken a Hydrocodone that day. This medication had previously been prescribed to her by her dentist. She was given an injection for pain and released to home with a diagnosis of muscle strain. She went to MD on 1/19/2006. X-rays revealed partial bony fusion/congenital non-segmentation of the C5-6 vertebral bodies with slight right foraminal narrowing and moderately advanced facet joint sclerosis at C6-7. She was diagnosed with left trapezius muscle strain and taken off work for 5 days. She returned to work restricted duty on 1/25/2006 and worked until 1/30/2006 when she was terminated by her employer, based on testing positive for opiates at the hospital, which one would have expected based on the fact that she had taken a Hydrocodone prior to going to the emergency room. On 2/7/2006 she complained to Dr of burning into her left shoulder and in a triangular shaped area in the left posterior section of her neck. She was diagnosed with neck pain and paresthesia consistent with cervical radiculopathy. A 2/11/2006 MRI showed a very mild disc protrusion at C4-5 with a degree of foraminal narrowing on the left and narrowed disc space at C5-6 from lack of segmentation.

She began care with DO on 3/6/2006, who diagnosed neck pain and cervical radiculopathy. Her pain drawing on

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3/7/2006 showed a small area of stabbing pain in the left posterior cervical region. Work Status Report released her to restricted duty (deskwork only) from 3/8/2006 through 5/8/2006. There is no indication that she ever tried to find other employment. She was referred to neurosurgeon, MD on 3/13/2006. Diagnosis was post-traumatic cervical syndrome with disc disease and radiculopathy. Cervical ESI on 3/24/2006 gave her no relief. Medications prescribed by Dr included Hydrocodone, Lyrica, Cyclobenzaprine, Amitriptyline, Ambien, Ibuprofen and Tramadol. She had 6 weeks of active physical therapy with Dr . Dr recommended an ACDF at C4-5 which was denied on 5/10/2006, based on minimal-small disc protrusion and no evidence of instability. Dr requested a Chronic Pain Management Program (CPMP) in 03/2006, which was denied. Cervicogenic headaches developed approximately mid 04/2006. Dr performed bilateral greater occipital nerve blocks on 5/1/2006 which were not effective. In a Contested Case Hearing on 5/9/2006, the decisions of the Hearing Officer were that the C4-5 disc protrusion was non-compensable, that the patient had not taken illegal drugs, and that her disability was due to her neck injury. On 6/6/2006 the pattern of her pain drawing is consistent with a somatoform disorder. Dr again requested a CPMP, which was denied on 6/19/2006, based on non-validated physiological endpoints, submaximal effort, and inadequate evidence of lower levels of rehab or progressive return to work. Dr dismissed the patient from her care on 7/10/2006. There is no submitted documentation regarding who the injured worker may have been seeing since that date for treatment or medication refills. There is a notice from the insurance carrier, CMI, to the patient dated 10/8/2007, in which the carrier was disputing ongoing disability and temporary income benefits. CMI stated that "after careful review of your file, it has been determined that you have not sought medical treatment in 60 days and it appears that you have abandoned medical treatment". The injured worker then sought care from DC, and exercised her right to choose him as her treating doctor.

She was first seen by Dr on 10/29/2007 complaining of constant 8/10 neck pain and stiffness. Examination revealed normal reflexes, positive cervical compression, severe cervical and occipital tenderness, upper trapezius trigger points, and moderately severe restricted ranges of motion. Request for physical therapy was denied, as it exceeded ODG guidelines and there was no barrier to a home exercise program. Request for CPMP has again been denied on 12/21/2007 and upheld on appeal on 1/7/2008. EMG/NCV performed on 1/23/2008 was completely normal, with no evidence of neuropathy, radiculopathy or plexopathy.

There have been 2 Designated Doctor Evaluations by MD dated 5/2/2006 and 2/20/2007, both of which did not certify maximum medical improvement (MMI). The first was based on the fact that Dr had recommended anterior cervical discectomy and fusion (ACDF) surgery, which was pending approval. The second was based on the fact that surgery was being appealed, and that Dr felt that the patient should have another trial of epidural steroid injection (ESI) at that time. Required medical examination was done by MD on 2/18/2008. He placed the injured worker at clinical MMI as of 6/13/2006, when Dr 's notes showed a static state in clinical findings. She was given a 5% impairment rating coming from cervical DRE Category 2. Dr stated that her current symptoms were consistent with myofascial pain syndrome, and that her pain drawing was somewhat extraordinary and not consistent with spinal elements. She reported her Hydrocodone dosage as one daily. Examination revealed non-dermatomal patterns of diminished sensation and 5/5 motor strength in the bilateral upper and lower extremities.

Over time, the injured worker has had 3 Functional Capacity Evaluations (FCE) performed. The FCE's on 3/7/2006 and 6/6/2006 showed that she could perform light duty at a 20 lb dynamic lift capacity. The dynamic tests did not include both pre and post heart rates to document maximum effort. Grip strength showed no bell-shaped curve (sub-maximal effort). The isometric strength and National Institute for Occupational Safety and Health (NIOSH) graphs were straight-line as opposed to appropriate curvilinear graphs, which should start at zero, ramp up to a peak by 2 seconds and then gradually descend. The FCE on 10/31/2007 showed that she could perform light-medium duty at a 25 lb dynamic lift capacity from the floor; however, the pre and post heart rates do not show the appropriate physiological increase in heart rate that is expected with maximum effort &/or a significant pain experience. The PDL Introduction section of the narrative states that she showed sedentary capacity for work above the waist; however, those dynamic lifts are not documented. All cervical ranges of motion are shown to be severely restricted, but the goniometer sensor has not been calibrated since 1/31/2007 so these may not be valid. All 3 FCE's do not provide any physiological evidence of deficiencies versus sub-maximal effort. Psychological/Clinical Interview was performed on 12/7/2007. The patient complained of 8-9/10 neck pain into the left more than right upper extremity and occipitofrontal headaches with medication, and 10/10 pain without medication. However, she was on fewer medications now than she was previously. Her current medications were Hydrocodone, Celebrex and Cymbalta. She had severe anxiety and moderate-severe depression. However, she had just been placed on 30mg Cymbalta by MD on 11/7/2007. She reported that she awakens every 3 hours due to pain, yet she was no longer taking any of the medications that would likely help with this problem (Ambien and Amitriptyline). Dr increased her Cymbalta to 60mg on 12/7/2007. Documentation shows 3 monthly office notes since that time, without any statement as to the therapeutic effects of this medication. CPMP reconsideration letter from Dr dated 12/28/2007 states that this is the first request for CPMP, which the documentation shows is clearly not the case. He also states that she has failed secondary treatment options, which also does not appear to be the case, as there is no evidence that she has participated in a Work Conditioning or Work Hardening program in the past. He states that previous methods of treating chronic pain have failed, which also does not appear to be the case, as there is no documentation of lower

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levels of psychological intervention with biofeedback and/or individual psychotherapy sessions. He also states that she has a history of increasing medication usage, when she is actually taking less medication now.

She has multiple negative predictors for treatment failure and treatment completion with a CPMP, according to ODG guidelines. There is also little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehab for neck and shoulder pain. Therefore, in accordance with the ODG guidelines, the previous denial is 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 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

**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)