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DATE OF REVIEW: 01/05/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management x 20 sessions

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

Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Employer's First Report of Injury or Illness, DOI
2. Medical Center activity reports 08/15/06, 08/28/06
3. 08/24/06
4. MRI of the cervical spine 08/24/06
5. CT scan of the head 09/19/06
6. Evaluation Dr. 09/05/06
7. Initial evaluation with Dr. 09/13/06
8. CT scan of the head 09/19/06
9. Reevaluation with Dr. 09/26/06
10. Initial evaluation with Dr. 09/28/06
11. Office visit Dr. 10/02/06, 10/26/06, 11/09/06, 11/13/06, 12/20/06
12. Office notes Dr. 10/26/06, 10/27/06, 10/31/06, 11/02/06, 11/03/06, 04/27/07
13. Initial behavioral consultation 11/07/06
14. Follow-up with Dr. 11/13/06
15. Investigation/Surveillance notes 10/24/06 through 11/04/06
16. Office notes with Dr. 12/05/06, 12/06/06, 12/07/06, 12/12/06, 12/13/06, 12/14/06, 12/18/06, 12/19/06, 01/23/07, 01/26/07, 01/30/07, 02/01/07, 02/13/07, 02/14/07, 05/04/07, 05/11/07

17. EMG/NCV 12/11/06
18. Psychotherapy progress notes
19. Functional Capacity Evaluation 01/12/07
20. Work hardening progress/group therapy notes
21. Functional Capacity Evaluation 03/06/07
22. Functional Capacity Evaluation 04/10/07
23. Reevaluation with Dr. 05/17/07
24. MRI of the left shoulder 06/19/07
25. Evaluation with Dr. 08/01/07
26. Electrodiagnostic studies 08/15/07
27. Electrodiagnostic study interpretation by Dr. 08/15/07
28. Physical therapy evaluation 08/20/06
29. Initial behavioral consultation 08/24/07
30. Follow-up with Dr. 08/15/07, 08/25/07, 09/08/07, 09/29/07, 11/03/07
31. Request for reconsideration for six sessions of individual physical therapy 09/11/07
32. Designated Doctor Evaluation 09/28/07
33. Neurosurgical consultation with Dr. 09/14/07
34. Functional Capacity Evaluation 09/20/07
35. Functional Capacity Evaluation 11/06/07
36. Individual psychotherapy notes
37. Requestor for twenty days of chronic pain management
38. Initial denial for twenty days of chronic pain management by Dr. 11/26/07
39. Letter of medical necessity from Dr. 11/26/07
40. Appeal to initial denial of twenty days of chronic pain management 11/30/07
41. Second Denial (Appeal) for 20 days of CPMP by Dr. 12/11/07
42. Request for IRO 12/18/07
43. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a female who sustained an injury to the head, neck, and shoulder. She reported she squatted down beside a moving conveyor belt and a co-worker pushed a 75 pound box causing it to fall off the conveyor belt striking the employee on the side of her head, neck, and shoulder.

The employee was seen for an initial evaluation and released with a diagnosis of concussion without loss of consciousness and a cervical strain. She was advised to remain off work and dispensed medications.

Initial complaints included neck pain, upper extremity weakness, numbness the digits, headaches, and a left eye discharge. Examination revealed a normal cervical examination, normal neurologic examination, decreased left grip strength, and decreased shoulder range of motion in flexion and extension.

Imaging studies of the head and neck were performed subsequent to the injury. An MRI of the neck revealed small annular bulges at C4-C5 and C5-C6 with mild bilateral foraminal encroachment. A CT of the head was unremarkable except for a focal area of mucosal thickening in the sphenoid sinus.

On 09/08/06, the employee requested a change of treating doctors and began seeing Dr. At that time, she was complaints of frequent left arm pain and paresthesia, neck pain, and headaches. Her medications included only Xanax per the notes provided. Examination revealed spasms, tenderness, and pain with compression testing, but no radiation of pain, mild decreased reflexes on the left, and hypesthesia consistent with C6-C7 dermatomal pattern. A treatment plan was formulated that included rest, medications, and chiropractic adjustments and was also referred to Dr. for evaluation.

Dr. diagnosed concussion, brain injury with ongoing headaches and emotional change, cervical strain, and shoulder injury. In addition to Xanax, Dr. prescribed Elavil. The employee was also taking Norgesic, which she had previously been prescribed for migraines, not related to the injury.

Over the course of the next few months, the employee continued to be seen regularly and received treatment modalities. Improvement was noted physically, however, her condition began to deteriorate emotionally.

On 10/24/06, LLC received a request for surveillance on the employee. For two days, 11/3/06 and 11/4/06, the employee's residence was surveilled but no activity or inappropriate behaviors were visualized.

On 11/07/06, the employee was seen for an initial behavior medicine consultation. At that time, the employee reported her severe pain was interfering with her life, activities, and ability to improve. She reported she was living with her husband and son and had a very good support system. Her medications included Xanax, Elavil and Norgesic. The employee also indicated her past medications had included Flexeril, Soma, Diclofenac, Cyclobenzaprine, and Celebrex. No prior psychological diagnosis or treatment was mentioned. She reported that as a result of her head injury, she was experiencing frequent headaches, dizziness, balance problems, visual "floaties", numbness in her fingers, and confusion. The employee also reported a loss of sense of control, loss of sleep, feeling like a burden, anger disappointment, uselessness, difficulty with intimacy, workers' compensation claim issues, and lack of confidence. Her symptoms were reported as all being 9/10 and/or 10/10. Beck Depression and Anxiety Inventories were completed; with scores of 38 and 26 respectively. The diagnosis was noted to be adjustment disorder with mixed anxiety and depressed mood, as well as sleep disorder due to head injury. She was recommended for placement on psychotropic medications and participation in individual psychotherapy. Treatment goals were to alleviate psychological distress by reducing Beck scores, decrease subjective complaints, increase sleep, develop return to work goals, reduce intimacy problems, and develop a behavioral contract. She was also recommended to be evaluated by a neuropsychologist to determine the extent of the traumatic brain injury.

An EMG and nerve conduction study was completed on 12/11/06. These studies were indicative of carpal tunnel syndrome in both extremities, very mild on the

right and mild on the left. The study was also suggestive of a chronic left C6 radiculopathy.

An initial Functional Capacity Evaluation (FCE) was completed on 01/12/07. The employee was determined to be at a sedentary to light physical demand level, this not meeting the required physical demand level of medium to heavy. She noted to have a fair prognosis and recommended for participation in a work hardening program. However, she was continued on her same treatment regimen and when seen for follow-up with no notable progress was noted.

In February, 2007, the employee began work hardening and completed ten sessions. There was a marked overall improvement noted. The employee was reported as focused, engaged, and motivated.

On 03/06/07, an interim FCE was completed. The employee was reported as having improved 11% in her right hand and 4% in her left. The physical demand level was at light. A continuation of work hardening was recommended, and another ten sessions were then completed.

On 04/10/07, another FCE was completed. At that time, the diagnosis remained unchanged, symptomology remained unchanged, and progress had plateaued and was hampered by chronicity. The prognosis was again noted as fair, and the employee was referred for chronic pain program consideration.

On 05/17/07, the employee was seen for follow-up by Dr. He instructed the employee to discontinue all therapeutic activities, passive therapies, and chiropractic care. The employee was also instructed to return in thirty days for an impairment rating evaluation.

On 06/19/07, an MRI of the left shoulder was completed and was unremarkable for a rotator cuff tear.

In August, 2007 the employee was seen again for follow-up with Dr. The employee reported intractable headaches and neck pain, clavicle pain, and pain radiating to her chest. The diagnostic impressions now included major depression, cervical radiculopathy, thoracic outlet syndrome, and left pectoralis syndrome. The employee was recommended to begin physical therapy and seek a neurology and neurosurgical consultations immediately.

On 08/15/07, a second EMG was completed. This study found no neuropathy in relation to plexopathy, polyneuropathy, mononeuropathy, and/or any primary muscle disease. The employee was referred back to the primary treating physician.

A physical therapy evaluation was completed on 08/20/07, and a physical therapy regimen was recommended.

On 08/24/07, a second behavioral medicine consultation was completed. Reported medications at that time included Xanax, Hydrocodone, and Zoloft.

The employee also reported financial stress, separation from her husband, increased family conflict, loneliness, feelings of abandonment, loss of sleep, loss of control, uselessness, and decreased participation in activities. She also endorsed depressed mood, change in appetite, fatigue, and diminished ability to think. Beck Depression and Anxiety Inventories revealed scores of 26 and 16 respectively. This was an improvement from the prior evaluation. A diagnosis was given as major depressive disorder and posttraumatic stress disorder secondary to work injury. The employee was again recommended for participation in individual psychotherapy. Treatment goals were to reduce mood, improve problem solving skills, reduce irritability, frustration, anxiety, sleep symptoms, and identify, challenge, and replace cognitive distortions and develop vocational plans.

Individual physical therapy was denied by utilization review citing no explanation had been given as to why the employee had not returned to work despite a job offer. A request for reconsideration was received with rebuttal letter citing the employee had not returned to work due to mood disturbance despite medications usage.

On 09/14/07, the employee underwent for a neurosurgical consultation with Dr. He opined surgical treatment was not required, as her neurological examination was normal without any evidence of nerve root compression. Dr. indicated only conservative management was needed.

On 09/28/07, the employee was seen for a Designated Doctor Evaluation. The reviewer opined that Maximum Medical Improvement (MMI) had been reached as of 08/28/07 with a 5% whole person impairment for the head and cervical injury.

The following day, 09/29/07, the employee was seen for follow-up by Dr. He reported the employee was not improving. The employee remained off work and was noted to be waiting on physical therapy approval.

When seen for follow-up on 11/03/07, Dr. noted the employee was improving and recommended continued physical therapy.

An FCE was performed on 11/06/07. The physical demand level was noted to be light. The findings indicated the employee was significantly deconditioned, and due to failure of a previous work hardening program, was recommended for chronic pain management.

In November, 2007, individual physical therapy was also resumed. The employee was reporting increasing stress due to her son moving away. She also continued with depressed mood due to inability to do her daily activities. At that time, she was also reported as filing for social security income. However, with these sessions pain, irritability, frustration, tension, anxiety, depression, and sleep were all improved. Upon completion of these individual physical therapy sessions, the employee was recommended for participation in a chronic pain management program. Goals were to wean narcotics, encourage contact with

her employer, increase activities of daily living, reduce fear/avoidance behaviors, reduce mood disturbances, and increase her physical demand level.

On 11/19/07, a request for twenty sessions of a chronic pain management program was denied by Dr., indicating the employee had previously met her physical demand level and had not returned to work despite availability of work. She also opined there was no clear explanation for recent decline in her condition.

On 11/26/07, a rebuttal letter regarding the denial of the chronic pain management program for this employee was submitted. She noted the employee was unaware of the job offer to return to work at modified duty. She also indicated the employee had stated even with light duty, any activities exacerbated her pain. Dr. indicated Dr. had also not released the employee to return to work due to the severity of her condition and deconditioning.

An appeal for twenty sessions of a chronic pain management program was also denied on 12/11/07 by Dr. Dr. indicated there has been no major subjective change in the employee's condition and this being the third request for a chronic pain management program from the same facility where work hardening was completed; this is duplicate and redundant care. Subsequently, a request for IRO has been filed.

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

Based on the information provided, I would have to agree with the initial and appeal determinations for denial. In my opinion, this employee has subjective complaints that significantly outweigh the objective findings and has been afforded treatment that should have brought her complaints to resolution.

As such, given the failure of all these treatments and also noting the employee, in my opinion, does not meet the criteria set forth for appropriateness for participation in a chronic pain management program, this request is respectfully denied.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

1. ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES