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Notice of Independent Review Decision

DATE OF REVIEW: 03/31/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Items in dispute: Outpatient chronic pain management program five days a week for four weeks

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

Board Certified Orthopedic Surgeon

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. Medical records by Dr. dated 02/27/07 thru 10/19/07.
2. EMG/NCV report dated 07/24/07.
3. Procedure report dated 08/17/07.
4. Medical records by Dr. dated 09/13/07 thru 11/01/07.
5. Procedure report dated 10/19/07.
6. Peer review by Dr. dated 11/27/07.
7. Designated Doctor Evaluation by Dr. dated 01/09/08.
8. Evaluation dated 01/22/08.
9. Letter of appeal dated 01/22/08.
10. Utilization review decision dated 01/31/08.
11. Utilization review decision dated 02/08/08.
12. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a female who is reported to have sustained an injury to her low back. The records suggest that the employee was carrying a 50 pound box when she had the development of low back pain.

The first available clinical record was dated 02/27/07 when the employee was seen by Dr. The employee presented with a history of low back pain, which was reported to be constant 8-9/10 with a pressure sensation across the low back, slightly worse on the left. There was a dull achy pain that radiated down the lateral and anterior aspect of her leg and down the posterior aspect of her leg slightly distal to the knee. There was no numbness or tingling. The employee denied any weakness in the leg, and her back pain was worse than the leg pain.

The employee had previously undergone an MRI of the lumbar spine on 02/19/07. This study reported a 1 mm bulge at L4-L5 abutting the thecal sac. At L5-S1, there was a 1 mm bulge abutting the thecal sac with a posterior annular tear in a right paracentral segment of the bulge. The employee had been treated with physical therapy and medications with minimal relief. She has not had any injection therapy. Upon physical examination, the employee was well developed and well nourished. She was alert and oriented times three. Gait examination was slow and slightly antalgic to the right side. She is able to heel toe walk with some pain. She had no evidence of a foot drop. Upon lumbar spine examination, she has markedly limited range of motion in forward flexion when compared to extension. She was significantly tender on the L5-S1, more off to the right side. She has an equivocal seated and supine straight leg raise on the right, positive on the left. She had a negative Faber's test. Deep tendon reflexes were 2+ at the knee and decreased at the ankles. There was a slight decrease in sensation in the lateral leg on the left side. Motor strength was intact. The employee was diagnosed with discogenic back pain and lumbar radiculopathy. Dr. opined that the employee's symptoms were most likely related to the L5-S1 disc and the annular tear with irritation of the nerve roots. Dr. recommended epidural steroid injections. The employee was provided oral medications.

The employee continued under the care of Dr. receiving monthly follow-up visits.

On 07/24/07, the employee was referred for an EMG/NCV of the lower extremities. This study reported electrophysiologic evidence of acute and chronic bilateral S1 radiculopathies. The employee further reported pain in the shoulder and arm and on 07/31/07 and was subsequently diagnosed with a shoulder contusion, an arm contusion, and a shoulder sprain. These records do not provide any indication of an intervening event.

On 08/17/07, the employee underwent bilateral S1 epidural steroid injections. When seen in follow-up, she reported 40% improvement with the injection.

The employee was referred to Dr. on 09/13/07. At that time, the employee reported 90% back pain and 10% bilateral leg pain, which she rated as 7-8/10.

She had received two injections with 40-50% improvement. She was further noted to have undergone physical therapy and had been on medications. Dr. recommended a trial of lumbar facet joint injections.

On 09/25/07, the employee received a corticosteroid injection into the left shoulder.

The employee was subsequently seen in follow-up on 10/04/07. Dr. again recommended facet injections, and reported if there was no improvement after facet injections, that the employee should undergo lumbar discography at L3-L4, L4-L5 and L5-S1.

The employee was seen in follow-up on 11/01/07. Dr. again recommended lumbar discography.

On 10/19/07, the employee underwent bilateral facet injections at L4-L5 and L5-S1.

When seen in follow-up on 11/13/07, the employee was reported to have obtained no improvement with the facet injections.

The records included a peer review dated 11/27/07 performed by Dr. Dr. opined that the compensable injury was limited to a strain of the soft tissues in the lumbar region. He found that a short course of physical therapy would have been appropriate. He indicated that the employee's treatment had been far in excess for the lumbar strain. He noted that the employee has multilevel degenerative spondylosis on MRI. Dr. recommended that the employee's oral medications be tapered and discontinued within a three month period. He noted that the previously requested discography was not supported by current evidence-based guidelines.

On 12/11/07, Dr. recommended that the employee undergo lumbar discography and reported that the employee had failed conservative care.

On 01/09/08, the employee was evaluated by a designated doctor, Dr. Dr. indicated that the employee reported pain down her back from her neck. It went to her right knee at the most distal portion. The employee rated her pain as a 7/10. Upon examination, the employee was reported to be well developed and well nourished. She walked with a normal gait. She no longer used a cane as she did on her examination on 08/03/07. She was in no acute distress. She was able to sit without difficulty and able to arise without difficulty. She could squat down to 50% of a full squat. Upon physical examination, tenderness was present which was more of achiness than true pain from L1 through S2. There were no muscle spasms or trigger points. Curvature was normal. Range of motion appeared to be decreased. Spurling's test was negative. Supine straight leg raise was positive at 60 degrees on the right and 75 degrees on the left. Seated straight leg raise was to 85 degrees both on the right and left side. Waddell's

tests were negative. It was reported that previously Waddell's testing on 08/02/07 was markedly positive. Babinski's test was negative. Reflexes were symmetric in the upper extremities. In the lower extremities, the patella reflex on the right was 1+ and on the left was 2+. Achilles reflexes were 1+ bilaterally. Sensory was intact in the upper extremities. Dr. reported the employee reported numbness on both the medial and lateral surfaces of the right thigh. Upon motor examination, there was no evidence of atrophy in the lower extremities. Motor strength was intact. Dr. found the employee to be at clinical Maximum Medical Improvement (MMI) and assessed a 5% whole person impairment.

On 01/22/08, the employee was referred to Health Management for psychiatric evaluation. The employee was subsequently recommended to participate in a chronic pain management program.

A request for 20 sessions of a chronic pain management program was submitted on 01/31/08. The reviewing physician opined that the employee had a one year old date of injury while carrying a 40-60 pound box. She complained of low back pain with radiation into the legs. He noted she had received physical therapy, medication, epidural steroid injections, and facet injections with no lasting relief. He noted that the employee lifted only 15 pounds which was limited by fear of pain, and no validity measures were noted. Psychological testing indicated a high level of fear of pain and reinjury. There was a discrepancy between her verbal reports of depression and anxiety and scores on Beck tests with no objective personality testing to clarify the cause. The employee had not received any secondary level of rehabilitation, physical or behavioral. There was no indication the employee had individual psychotherapy or behavioral pain management training. There was no discussion of the relationship between the employer or return to work plans. As a result, the reviewing physician recommended non-certification of the request.

This was appealed on 02/08/08. The reviewing physician found the original decision as being appropriate and recommended non-authorization. The reviewing physician noted that under **Official Disability Guidelines** criteria for general use of a multidisciplinary pain management program outpatient 1) that there be adequate and thorough evaluation has been made to include baseline functional testing so follow-up with the same tasks can note functional improvement, 2) that the claimant was not a candidate where surgery or other treatment would clearly be warranted. He noted that with respect to whether or not the claimant was a surgical candidate or not, there had been two requests for discogram and no new notes were submitted from the treating provider, indicating that he did not feel that surgery was an option for the claimant. He further noted that there were six negative particulars of success that had been addressed. He further reported that there did not appear to be an assessment regarding the relationship of the employer with her supervisor, her degree of work adjustment satisfaction which are part of the negative particulars that are supposed to be assessed according to **Official Disability Guidelines**. Finally with respect to the measures of subjective functioning, there were no valid

measures of the employee's physical performance, thus the medical necessity could not be established.

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

I would concur with the previous reviewers in that the medical necessity for a chronic pain management program was not established by the submitted clinical information. It was noted that the employee had multiple barriers which are poor predictors of success. Additionally, the records that were provided have not excluded the employee as an operative candidate as required by the ***Official Disability Guidelines***.

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

1. The ***Official Disability Guidelines***, 11th edition, The Work Loss Data Institute.