



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 02/12/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 10 sessions of chronic pain management

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Radiology report cervical spine dated 03/17/07
2. Radiology report lumbar spine dated 03/17/07
3. Initial comprehensive evaluation dated 04/04/07
4. Medical records Dr.
5. Oswestry Low Back Pain Disability Questionnaire dated 05/03/07
6. Neck Disability Index
7. Initial diagnostic screening dated 06/07/07
8. Patient pain drawing dated 06/07/07
9. TWC Work Status Reports
10. MRI of the cervical spine dated 06/20/07
11. MRI of the lumbar spine dated 06/20/07
12. Utilization review determination dated 06/21/07
13. Consultation note from Dr. dated 07/05/07
14. Electrodiagnostic studies dated 07/09/07
15. History and physical dated 07/10/07
16. Utilization review determination dated 07/17/07
17. Pain and mental health progress report dated 07/17/07
18. Cervical myelogram with post myelogram CT dated 07/27/07

19. Cervical spine series dated 07/27/07
20. Procedure/recovery room notes dated 07/27/07
21. Procedure charge sheet dated 07/27/07
22. Psychological evaluation dated 10/26/07
23. Functional capacity exam dated 10/29/07
24. Designated doctor examination dated 12/07/07
25. Functional capacity evaluation dated 12/14/07
26. Follow up note Dr. dated 02/06/08
27. Follow up note Dr. dated 02/07/08
28. Utilization review determination dated 03/13/08
29. Follow up note Dr. dated 05/07/08
30. Discharge summary dated 05/10/08
31. Operative report dated 05/09/08
32. Medical records Dr.
33. Physical performance evaluation dated 08/25/08
34. Functional abilities evaluation dated 09/22/08
35. Interdisciplinary pain rehabilitation program daily progress notes
36. Psychological evaluation dated 10/27/08
37. Work hardening program daily progress notes
38. timecard detail report
39. Functional capacity exam dated 11/12/08
40. W-9 form dated 08/25/08
41. Designated doctor examination dated 12/02/08
42. Work hardening treatment plan
43. W-9 form dated 09/25/08
44. Request for appeal dated 12/22/08
45. Utilization review determination dated 12/08/08
46. Utilization review determination dated 12/31/08
47. Psychological evaluation dated 02/27/08
48. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a xx year old female whose date of injury is listed as xx/xx/xx. On this date, the employee reportedly slipped on some liquid substance that was on the floor as she was walking through the meat processing area, fell, and injured her low back. The employee reported that her neck was sore because she hit the back of her head on the floor.

Three views of the cervical spine performed on xx/xx/xx revealed no signs of a cervical spine fracture, reversal of the expected lordotic cervical curvature which may indicate muscle spasm, and interspace narrowing of the C5-C6 level indicating degenerative change. Lumbar spine radiographs on this same date revealed minor dextrorotational scoliosis and no evidence of an acute fracture.

Initial comprehensive evaluation on 04/04/07 indicated that the employee complained of low back pain and neck pain. Assessment was reported as neuralgia, neuritis, and radiculitis, unspecified; displacement of lumbar intervertebral disc without myelopathy; disorders of muscle, ligament and fascia; sprain of unspecified site of shoulder and upper arm; and displacement of cervical intervertebral disc without myelopathy. The

employee was found to be suffering from acute low back pain. The left shoulder pain appeared to originate from the cervical region. The employee had decreased range of motion with hypertonia to the cervical and lumbar paraspinal musculature. The employee was prescribed medications and recommended to participate in an active rehabilitation program. The employee subsequently completed twelve sessions of physical therapy and serial follow-ups indicated that the employee reported slight improvement in low back pain and neck pain.

Oswestry Low Back Pain Disability Questionnaire dated 05/03/07 revealed a score of 18.

The employee underwent initial diagnostic screening on 06/07/07. The employee reportedly exhibited mild anxiety when discussing her losses. The employee's mood was depressed and her affect was sad. The employee reported being nervous thinking about her future. She stated she felt overwhelmed with life right now. The employee was very frustrated with herself due to her inability to perform activities she did prior to the accident. Beck Depression Inventory was reported as 23 and Beck Anxiety Inventory is 28. On the FABQ, she scored 24 out of 24 on the Fear-Avoidance of physical activity or 100% and on the Fear-Avoidance of work she scored 38 out of 42 which is 90%. The employee has reportedly received one injection and previously underwent physiotherapy at the rate of three days per week. The employee was taking Tramadol and Skelaxin and rated her pain as 5-6/10. The employee was recommended for a short course of individual psychotherapy and was diagnosed with pain disorder associated with both psychological factors and a general medical condition.

The employee was referred for consultation to Dr. on 07/05/07. The employee rated her pain as 5/10. The employee was diagnosed with cervical radiculopathy, herniated nucleus pulposus at C5-C6 and cervicalgia and recommended physical therapy and a CT myelogram of the cervical spine.

The employee underwent electrodiagnostic studies on 07/09/07. Behavioral observations reported that the employee did not report or demonstrate any obvious signs of depression, anxiety or other behavioral pathology. The employee reported minimal cervical spine pain but no complaints in the upper extremities. The employee reportedly had findings consistent with bilateral L5-S1 radiculopathies.

Pain and mental health progress report dated 07/17/07 reported that the employee's pain level was now 7/10. BDI was now 19 and BAI was 21. Pain had reportedly significantly disrupted the employee's activities of daily living. The employee was again recommended for a course of individual psychotherapy.

The employee was subsequently approved for eight additional sessions of physical therapy, and serial follow-up notes indicated that the employee reported slight improvement in low back pain and neck pain.

The employee underwent psychological evaluation on 10/26/07. The employee was not currently working and would like to return to work, and felt discontent and apprehensive. The employee rated her pain as 7-9/10. The employee reported difficulty sleeping, fatigue, irritability, crying spells, sadness, fearfulness, anger, frustration, nervousness,

weight changes, agitation, dizziness, and muscle tension. BAI was reported as 49 and BDI was 38. The diagnosis was chronic pain resulting from work injury of. The employee was recommended for participation in a work hardening program.

The employee underwent a Functional Capacity Evaluation (FCE) on 10/29/07 which reported that the employee's required physical demand level was very heavy and the employee's current physical demand level was sedentary.

The employee underwent Designated Doctor Evaluation on 12/07/07 which found that the employee had reached Maximum Medical Improvement (MMI) as of 12/07/07 with a 5% whole person impairment rating. It was reported that the employee's condition was medically stable and would not be significantly changed by further treatment. The extent of the compensable injury was reported as cervical strain; lumbar muscles and ligaments and disc.

The employee subsequently underwent a second FCE on 12/14/07 which reported that the employee's required physical demand level was medium and her current physical demand level was below sedentary.

The employee was seen by Dr. on 02/06/08, at which time Dr. reported that the employee was not a surgical candidate and recommended continued conservative treatment. However, a follow-up note from the following day, 02/07/08, reported that the employee was a surgical candidate and recommended lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1.

The employee underwent psychological evaluation on 02/27/08. BDI was reported as 5 and BAI was reported as 8. Diagnosis was listed as chronic pain resulting from work injury of xx/xx/xx. It was reported that the employee displayed an essentially normal mental status examination with minimal symptoms of depression and mild symptoms of anxiety.

The employee subsequently underwent lumbar laminectomy and microdiscectomy at L5-S1 on 05/09/08. The employee's postoperative course was reportedly unremarkable.

On follow-up on 05/20/08, the employee reported near complete resolution of her preoperative symptomatology. Serial follow-up notes from Dr. indicated that the employee began to complain of increased lower back pain postoperatively; however, follow-up notes from Dr. indicated that the employee continued to relate marked improvement from her preoperative symptomatology.

The employee underwent a physical performance evaluation on 08/25/08 which reported that the employee could not safely return to her previous occupation.

The employee subsequently underwent a functional abilities evaluation on 09/22/08 which reported that the employee was not currently working but did have a position to return to. The employee's required physical demand level was reported as medium to heavy and the employee's current physical demand level was sedentary to light. The

employee was recommended to continue physical therapy, be provided injections, and to undergo psychological evaluation.

The employee underwent a psychological evaluation on 10/27/08 to determine her appropriateness for a work hardening program. Treatment to date was noted to include physical therapy, injections, surgery, and work hardening with minimal reported benefit. The employee reported sleep disturbance, weight changes, agitation, and fatigue. The employee's thought content included a sense of failure, self-critical, worry, and guilt. BDI was reported as 15 and BAI was 23. Diagnoses were listed as chronic pain disorder, anxiety disorder, and depressive disorder. Assessment results reportedly indicated that the employee could psychologically endure the rigors of a work hardening program.

The employee was subsequently enrolled in a work hardening program. Daily progress notes dated 11/03/08 reported that the employee had a poor attitude toward recovery, poor motivation, poor pain management, poor work ethic and ability to follow rules, poor time management skills, and the employee was giving questionable effort into the program. A progress note from week two indicated that the employee had not improved motivation, injury or pain management, work ethic and ability to follow rules, or time management skills. The employee reportedly displayed poor effort in the program. A work hardening progress note dated 11/11/08 upon completion of three weeks in the program indicated that the employee's BDI had increased from 9 to 43 and BAI increased from 11 to 33. The employee only attended 40% of her scheduled visits in week three. Dynamic lifting did not improve and the employee's work level remained at sedentary. Standing and walking endurance improved by five minutes, but sitting endurance remained stable. Cardiovascular endurance only slightly improved. The employee reportedly intermittently followed instructions of staff, body mechanics were poor, pace during the program was poor, and the employee exhibited maximum pain behaviors.

The employee underwent an FCE on 11/12/08 which reported that the employee had completed ten sessions of work hardening. The employee's required physical demand level was heavy. The employee reportedly showed severe signs of decreased functional ability of the lumbar spine and had expressed an overall poor attitude of being able to return to work and normal activities of daily living.

A Designated Doctor Evaluation performed on 12/02/08 reported that the employee was not at MMI and noted that estimated MMI was within three months.

A subsequent request for chronic pain management program was denied based on a lack of evidence of exhaustion of lower levels of care and that FCE and psychological evaluation had recommended continued work hardening. The appeal request indicated that a chronic pain management program was more appropriate, as the employee did not have a job to return to, and the employee's psychological symptoms escalated in work hardening secondary to increased physical activity and pain complaints. It was reported that the employee participated in work hardening prior to her May, 2008 surgery. The appeal request was again denied on 12/31/08 noting that psychometric assessments on psychological evaluation were inadequate to support the diagnoses or explicate the clinical problems.

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

I concur with the two previous reviewers that ten sessions of chronic pain management are not medically necessary for this employee. The employee sustained an injury to the low back as a result of a slip and fall occurring on xx/xx/xx. The employee subsequently underwent a course of conservative care followed by enrollment in a work hardening program. Progress notes from the work hardening program indicate that the employee exhibited a poor attitude, poor motivation, poor pain management, poor work ethic and ability to follow rules, poor time management skills, and effort in the program ranged from questionable to poor. The employee's Beck scales increased during the program, and the employee only very minimally improved. During the third week of the program, the employee only attended 40% of her scheduled visits. The records indicate that the employee intermittently followed instructions of staff, displayed poor body mechanics and pace, and exhibited maximum pain behaviors. The employee has undergone several psychological evaluations, and there was inconsistent reporting on Beck scales throughout the submitted records. The employee's subjective complaints appear to outweigh any objective findings.

Given the employee's poor effort and performance in a previous rehabilitation program as well as inconsistent psychological assessments, a chronic pain management program is not appropriate for this employee and is not medically necessary

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

1. *Official Disability Guidelines*