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Notice of Independent Review Decision

DATE OF REVIEW: 09/09/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Retrospective: Medications DOS 5/23/09 and 6/5//09

REVIEW OUTCOME

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

(Upheld) (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 12-29-08 CT, abdomen and pelvis read by Dr.
- 02-04-09 Initial Complex Orthopedic Examination report from Dr.
- 02-09-09 Peer Review from Dr.
- 02-10-09 Lumbar and Thoracic MRI as read by Dr.
- 02-11-09 Electrodiagnostic studies interpreted by Dr.
- 02-24-09 Radiology report - Bone scan read by Dr.
- 02-24-09 Radiographic reports, left hip, chest and ribs read by Dr
- 03-02-09 Medical report Dr.
- 03-02-09 Designated Doctor Report - MMI report, from Dr.
- 03-18-09 Functional Capacity Evaluation performed and interpreted by , DC
- 03-18-09 Dynamic Surface Electromyogram, interpreted by , DC
- 03-25-09 Medical report, Dr.
- 04-06-09 Procedure report, SI joint injection from Dr.
- 06-16-09 Internal carrier fax noting denial of medications based on peer
- 04-17-09 Medical report from Dr.
- 05-04-09 Medical report from Dr.
- 06-05-09 Medical report from Dr.
- 07-20-09 Pharmacy receipt, 25.80 for two medications
- 08-04-09 Request for reimbursement from , Esq.
- 08-05-09 Explanation of Benefits from TDI, Zolpidem and hydrocodone
- 08-10-09 Request for IRO from the Claimant
- 08-13-09 Assignment of IRO notice from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a xx-year-old who sustained an industrial injury

to the left hip and left shoulder on xx/xx/xx when he fell from scaffolding. CT scan performed December 29, 2008 revealed no acute abdominal or pelvic injury and a single calcified gallstone without billary ductal dilation.

The claimant was provided an orthopedic consultation on February 4, 2009. The patient has been treated for several months without adequate progress. He reports left-sided body pain of 8/10. He fell about 5 ½ feet. He went to ER. CT scan revealed a normal abdominal study except for a benign gallstone. He has had multiple x-rays of the spine and ribs without any acute changes noted. He has had 12 sessions of PT and tried Lyrica and hydrocodone, which have been discontinued. He was released to light duty and then to full duty as the employer could not accommodate light duty. He has a slight left antalgic gait. There is pain with palpation at the left superior iliac crest and chest wall in the midaxillary line to compression. He reports pain in the axilla. There is hip pain with motion and tenderness over the femoral head. Deep inspiration and cough reproduce the left chest wall pain. Impression is rib cage contusion, with possible pleurodynia, thoracolumbar syndrome and left hip contusion. Recommendation is for a bone scan, EMG left lower extremity, thoracic and lumbar MRIs and hip x-rays. The patient's symptoms/history form notes he is not currently on medications.

The handwritten orthopedic reevaluation notes of March 2, 2009 and March 25, 2009 indicate the patient has been put on the medication Lortab.

According to a Peer Review dated February 9, 2009, the patient's medical history includes ORIF right calcaneous in 1993. The patient was provided medication of Hydrocodone/APAP 10-500 and Tramadol 50 mg on November 29, 2008 and again on December 12, 2008 for Hydrocodone/APAP and Skelaxin 800 mg. The patient was given a script for PT for a chest wall contusion and back pain on December 17, 2009. The patient reported pain of 10/10 to the left lower back, hip and chest. As of December 23, 2008 the patient ambulated with a severe antalgic gait and movement patterns. The patient attended 12 sessions of PT during the period of December 22, 2008 through January 9, 2009. He was compliant with HEP but was not making satisfactory progress. He had shown minimal subjective improvements in his condition. A therapy note of January 19, 2009 indicated the patient had completed PT and has what the therapy notes described as "the same inconsistent pain response." The pain is no better than the day he was injured. There was point tenderness to the left lower ribs, and no abdominal tenderness. He was tender to palpation over the left SI joint. There were no radicular signs and symptoms. Straight leg raising was negative. Multiple objective tests were negative. He was given a full release to work. The diagnosis was chest contusion and lumbar strain. He was MMI on January 19, 2009 with zero impairment. The only treatment needed at this point would be HEP and anti-inflammatory medications. He had 12 physical medicine visits without improvement. Tramadol and Skelaxin are no longer needed and should be weaned.

Lumbar MRI was performed on February 10, 2009 and provided impression of, multilevel dessication of the discs, in particular, L1-L2 with a posterior herniation, and L3-4 and L4-5 levels. Thoracic MRI of the same date revealed, T5-6 posterior minimally protruding disc. Exact level would be better identified with a complete C, T, and L series.

The claimant underwent electrodiagnostic testing on February 11, 2009 per referral of his orthopedic provider. The impression states, the overall findings showed evidence of moderate right sural sensory neuropathy. EMG showed evidence of severe, chronic left L5 radiculopathy.

Bone scan performed February 24, 2009 noted areas of increased activity involving the left posterolateral ribs consistent with prior trauma. Pelvis, skull and long bone activity is normal. X-rays of the left hip revealed a normal study. Chest x-rays were interpreted as normal. Rib x-rays were negative.

The claimant was seen for a Designated Doctor Examination on March 2, 2009. The claimant reported lower back pain and pins and needle sensations into the left lower extremity to the foot. He reported left shoulder pain and weakness that extended onto the left arm. He also reported left sided hip and pelvis symptoms and left elbow symptoms. The claimant reported a pain level of 7/10. He estimated his overall improvement at 20% and his overall disability as 45%. He is using one or more prescription drugs. Abdominal CT scans were performed and interpreted as unremarkable. MRI performed November 21, 2008 and December 24, 2008 were interpreted as normal. Neuro-electrodiagnostic tests performed February 11, 2009 revealed objective evidence of radiculopathy of the L5 nerve which correlate with his subjective findings and clinical examination findings.

Per the DD exam the patient is 6' 1" and 175 pounds. Global range of motion increased his pain so specific range of motion was not tested. Dynamic Surface Electromyography performed March 18, 2009 showed myopathology of the lumbar paraspinal muscles in the form of muscle spasms and guarding. Shoulder range of motion was not performed. Motor testing showed 5/5 strength is all groups tested. Per DD opinions, the claimant is not at MMI and is at a sedentary PDL while his job requires a medium to heavy PDL.

Per request of the DD a FCE was performed on March 18, 2009. Testing was interpreted as showing physical and functional deficits in posture, muscle activity, muscle strength, ranges of motion, balance and gait and an inability to perform regular work duties. The Heel walk test (L4) and Toe walk (S1) were positive on the left. Left elbow testing showed positive Cozen's, Mill's and Tinel's tests. The patient was determined to have a diagnosis of lumbar radiculopathy, shoulder sprain, elbow sprain, and left hip unspecified site. MMI was estimated to be realized about 7-3-09. The claimant's PDL was interpreted to be sedentary, able to lift up to 10 pounds maximum, occasionally.

Per request of the DD Dynamic SEMG testing was performed on March 18, 2009 and were interpreted to indicate abnormal

muscle function and physiology in the lumbar spine. Spasms and asymmetry of motion were documented. There are physical and functional related muscle deficits that could adversely affect his ability to safely and effectively perform work duties.

The patient was administered a left SI joint steroid injection by his orthopedic provider on April 6, 2009. The follow-up notes of April 17, 2009 note no benefit was obtained from this injection. The claimant reports numbness of his left arm, headaches and left buttock and thigh pain that keeps him up at night. Tenderness is noted over the SI joint and a positive Gaenslen and left straight leg raise. There is indication of left L5 type sensory loss. His urinalysis indicated marijuana use, which he denied. Therefore no further narcotic refill would be provided until a repeat urinalysis is negative.

The medical notes of May 4, 2009 indicate the patient has been recommended for an EMG. A urine test will be done prior to refilling hydrocodone. Ambien #30 was refilled.

At reevaluation on June 5, 2009 the patient reports low back pain that radiates into the left leg and numbness on occasion in the left 4th and 5th fingers. He is noted to be very anxious and weepy. C6 radiculopathy on the left is noted. He has been denied a recommendation for brain MRI. The specialist wants a CT myelogram. Recommend EMG left arm, repeat psyche management and refill meds. There is concern for the way the patient's case is being controlled by the carrier, especially given the DDE ruled in the patient's favor.

Request for payment of medications of zolpidem (Ambien) and hydrocodone, cost of $25.80, was denied on August 5, 2009 by the carrier with rationale that the medications represented unnecessary medical treatment based on peer review opinions.

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

The patient fell about 5 feet and was treated for several months attendeding 12 sessions of PT and prescribed Lyrica and hydrocodone, without significant benefit. The medications were discontinued and he was released to light duty and then allowed full duty as the employer could not accommodate light duty.

The patient came under orthopedic management and was put back on narcotic medication (Lortab).

A peer review of February 9, 2009 noted comments from the physical therapist such as he exhibits "the same inconsistent pain response." The reviewer noted point tenderness to the left lower ribs, and no abdominal tenderness. He was tender to palpation over the left SI joint. There were no radicular signs and symptoms. Straight leg raising was negative. Multiple objective tests were negative.

MRI of February 2009 revealed, multilevel dessication of the discs, in particular, L1-L2 with a posterior herniation, and [dessication at the] L3-4 and L4-5 levels. EMG has shown evidence of severe, chronic left L5 radiculopathy. This finding does not correlate well with the MRI scan. A bone scan revealed areas of increased activity involving the left posterolateral ribs consistent with prior trauma. Per the Designated Doctor examination, neuro-electrodiagnostic tests reveal objective evidence of radiculopathy of the L5 nerve which correlate with his subjective findings and clinical examination findings, however not with the MRI results. An FCE was interpreted to show the claimant's PDL to be sedentary. Left elbow orthopedic testing noted several positive tests. SEMG testing indicated abnormal muscle function and physiology in the lumbar spine. At reevaluation in April the provider noted tenderness over the SI joint and a positive Gaenslen test. Left straight leg raise is positive. There is indication of left L5 type sensory loss. In May 2009, a urine test was planned prior to refilling hydrocodone. Ambien #30 was refilled. At the current submitted reevaluation of June 2009, the claimant is noted to be very anxious and weepy. A brain MRI has been denied. Additional psyche treatment is recommended. He is prescribed Ambien and Lortab which were subsequently denied.

The patient was off medications until he initiated treatment with his current provider. He has chronic left L5 radiculopathy per EMG, not clearly corroborated with MRI results. Numbness on occasion in the left 4th and 5th fingers is also reported along with C6 radiculopathy which also do not correlate well. There is also SI joint tenderness with history of a more recent injection.

In January 2009 the provider noted negative straight leg raising, and multiple objective tests were negative. He was given a full release to work. The diagnosis was chest contusion and lumbar strain. The patient was MMI on January 19, 2009 with zero impairment. Per Peer Review of February 2009, the only treatment needed at this point would be HEP and anti-inflammatory medications. The patient is demonstrating use of hydrocodone and has been using Ambien for more than 6 weeks.

Ambien is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia only. Ambien should not be used on a chronic basis. The most recent interventional treatment provided is an SI joint injection. The patient appears to have mechanical back pain versus neuropathic pain and a narcotic medication would not be indicated. The MMI report recommendations for HEP and anti-inflammatory medications appear to be appropriate. Therefore, my determination is to agree with the previous non-certification of the request for medication DOS 5/23/09 and 6/5//09, retrospectively.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines - Pain Chapter (8-24-2009), Hydrocodone (Vicodin, Lortab):

Hydrocodone or is a semi-synthetic opioid which is considered the most potent oral opioid that does not require special documentation for prescribing in some states (not including California). See Opioids.

Zolpidem (Ambien): Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. (Feinberg, 2008)