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Notice of Independent Review Decision

DATE OF REVIEW: 07/23/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Chronic Pain Management 97799 x 10 sessions

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

Texas Board Certified Physical Medicine & Rehabilitation

Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 07/30/09 - Physical Medicine Note -, DC
2. 08/04/09 - Physical Medicine Note -, DC
3. 08/06/09 - Physical Medicine Note -, DC
4. 08/07/09 - Physical Medicine Note -, DC
5. 08/10/09 - Physical Medicine Note -, DC
6. 08/11/09 - Physical Medicine Note -, DC
7. 08/13/09 - Radiographs Lumbar Spine
8. 08/13/09 - MRI Lumbar Spine
9. 08/14/09 - Physical Medicine Note -, DC
10. 08/17/09 - Physical Medicine Note -, DC
11. 08/19/09 - Physical Medicine Note -, DC
12. 08/21/09 - Physical Medicine Note -, DC
13. 08/24/09 - Physical Medicine Note -, DC
14. 08/26/09 - Physical Medicine Note -, DC
15. 08/28/09 - Physical Medicine Note -, DC
16. 08/31/09 - Physical Medicine Note -, DC
17. 09/02/09 - Physical Medicine Note -, DC
18. 09/30/09 - Operative Report
19. 10/20/09 - Clinical Note -, MD

- 20. 11/12/09 - Clinical Note -, MD
- 21. 12/29/09 - Designated Doctor Evaluation
- 22. 01/05/10 - Clinical Note -, MD
- 23. 02/01/10 - Clinical Note -, MD
- 24. 02/02/10 - Clinical Note -, MD
- 25. 02/12/10 - Operative Report
- 26. 02/25/10 - Clinical Note - RN, FNP
- 27. 04/06/10 - Clinical Note -, MD
- 28. 04/20/10 - Clinical Note -, MD
- 29. 05/04/10 - Clinical Note - , MD
- 30. 05/10/10 - Clinical Note -, MA, LPC
- 31. 05/11/10 - Clinical Note -, MD
- 32. 06/01/10 - Psychotherapy Notes -, PsyD
- 33. 06/03/10 - Psychotherapy Notes -, PsyD
- 34. 06/08/10 - Psychotherapy Notes -, PsyD
- 35. 06/08/10 - Clinical Note -, MD
- 36. 06/10/10 - Psychotherapy Notes - PsyD
- 37. 06/14/10 - Physical Therapy Notes -, PT
- 38. 06/22/10 - Clinical Note -, MD
- 39. 06/22/10 - Clinical Note -, MD
- 40. 07/07/10 - Functional Capacity Evaluation
- 41. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury when he stepped awkwardly into a hole and twisted his low back.

The clinical notes begin with an evaluation by Dr. on 07/30/09. The employee complained of constant bilateral lower lumbar pain rating 7 out of 10 on the VAS scale. The physical examination revealed negative straight leg raise. There was pain and spasm to palpation. There was decreased range of motion. No exact measurements were given. The employee was assessed with lumbago, muscle spasm, and lumbar sprain/strain. The employee was recommended for electrical stimulation, ultrasound, manual therapy, and therapeutic exercises.

The employee returned to Dr. on 08/04/09 with reports of improved low back pain since his initial visit. The employee was issued and instructed on the use of a portable TENS unit.

An MRI of the lumbar spine performed 08/13/09 demonstrated mild multilevel disc and facet degenerative disease. At L4-L5 there was a mild diffuse disc bulge asymmetric to the left with small superimposed central and left paracentral disc protrusion and probable extrusion with encroachment on the lateral recesses and neural foramina. Radiographs of the lumbar spine performed 08/13/09 demonstrated mild multilevel disc and facet degenerative disease. The employee was treated with electrical stimulation, ultrasound, manual therapy,

and therapeutic exercises. The employee was seen regularly three to four times weekly for continued electrical stimulation, ultrasound, manual therapy, and therapeutic exercises until 09/02/09.

The visit of 09/02/09 stated the employee rated his pain at 1 out of 10. The employee's chief complaint was a dull ache down both legs. The physical examination revealed improved range of motion, although it was still decreased with flexion. Again, no actual measurements were provided. The employee was referred to pain management for injections.

The employee underwent a caudal epidural steroid injection at L4-L5 on 09/30/09.

The employee saw Dr. on 10/20/09. The employee stated his pain had decreased by at least 50 to 60% since the epidural steroid injection. The employee was attempting a home exercise program. He was not interested in lumbar spine surgery at that time. He denied bowel or bladder incontinence. The physical examination of the lumbar spine revealed improved range of motion with flexion to 60 to 65 degrees and extension to 20 degrees. Straight leg raise was negative bilaterally. There was minimal tenderness to palpation of the lumbar paraspinal muscles. The employee was recommended for a second diagnostic caudal epidural steroid injection with post-injection physical therapy.

The employee saw Dr. on 11/12/09 with complaints of low back pain with radiation to the bilateral legs. Current medications included Norco 10/325mg, Celebrex 200mg, Soma 350mg, and Norvasc. The physical examination revealed normal cervical range of motion. There was normal lumbar range of motion with pain. There was no evidence of subluxation, dislocation, or laxity. The employee was returned to work with restrictions.

A Designated Doctor Evaluation was performed on 12/29/09. The physical examination revealed L1 scoliosis. The employee ambulated with a slight limp. He was able to walk on his toes and heels without difficulty. There was no tenderness to palpation. Range of motion was mildly decreased with flexion and extension. The employee was assessed with lumbar strain. The employee was not placed at MMI at that time.

The employee saw Dr. on 02/01/10 with complaints of bilateral low back pain that radiates to both legs in an L5 distribution. He also reported numbness and tingling as well as a deep seated aching pain that radiated down both legs. He denied bowel, bladder, or sexual dysfunction. The employee rated his average pain at 7 out of 10 on the VAS scale. Physical examination revealed an antalgic gait. Straight leg raise was positive bilaterally. The employee was assessed with back pain, lumbar radiculopathy, lumbosacral disc disease, and lumbar sprain/strain. The employee was prescribed Robaxin 750mg, Celebrex 200mg,

and Norco 10/325mg. The employee was recommended for a second epidural steroid injection.

The employee underwent a lumbar translaminar epidural steroid injection to L4-L5 on 02/12/10.

The employee was seen for follow up on 02/25/10. He reported improvement in his pain since the injection. He now rated his pain at 4 out of 10. Physical examination revealed tenderness to palpation over the lumbar spine with spasm noted bilaterally. There were moderate facet features noted at L4-L5 bilaterally. Straight leg raise was positive bilaterally. There was decreased sensation on the left in a L4 and L5 distribution. The employee was recommended for a repeat epidural steroid injection. Following this, he would be recommended for a pain program.

The employee returned to Dr. on 04/20/10. The request for a second epidural steroid injection was denied. Physical examination revealed tenderness to the left paravertebral area near the lumbosacral junction with increased muscle tone. Straight leg raise was positive for increase of radicular dysesthesias in the left L5 dermatome. There was fairly stable moderate hypoesthesia in the left L5 dermatome. Dr. did not recommend back surgery, and the employee would like to save surgery as a last resort. The employee was recommended for a chronic pain management program.

The employee was seen on 05/10/10 to determine if he was a candidate for a chronic pain management program. The employee complained of low back pain that radiated down his left leg and into his foot. He rated the pain at 6 out of 10. The pain worsened with walking and standing. Previous treatment included injections and physical therapy with minimal relief. The employee complained of insomnia, sadness/depression, decreased appetite, and short temper. His BAI score was 5, indicating minimal anxiety. His BDI score was 21, indicating moderate depression. The employee was recommended for four individual psychotherapy sessions. If there was no significant progression, he would be recommended for a chronic pain management program.

The employee attended four individual psychotherapy sessions from 06/01/10 to 06/10/10. The employee was noted to have displayed positive response to cognitive behavioral techniques. He was able to identify and process negative and distorted cognitions, able to refute the irrationality of those thought, and reframe them into positive coping statements. The employee was recommended for chronic pain management program.

A chronic pain management evaluation is performed on 06/14/10. The physical examination revealed full range of motion of the cervical spine, lumbar spine, elbow, and wrist. The employee's Modified Oswestry Pain Scale score was 38.

The employee was able to lift a maximum of 56 pounds. The employee was recommended for twenty sessions of chronic pain management.

The request for the chronic pain management program was denied by utilization review on 06/18/10 due to minimal physical findings and lack of documentation that the employee has failed conservative management of care.

The employee saw Dr. on 06/22/10. The employee continued to experience low back pain. He did not feel that he was able to return to work with his current level of pain and dysfunction. The physical examination was stated to be unchanged. The employee was refilled Norco, Robaxin, and Celebrex.

A Functional Capacity Evaluation (FCE) was performed on 07/07/10. The employee passed 85% of the validity criteria, indicating that he did exert maximal effort. The employee's occupation required a heavy physical demand level, while the employee was currently functioning at a light to medium physical demand level.

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

The provided clinical documentation supports the request for ten sessions of chronic pain management. The clinical documentation sufficiently documents the employee's conservative care to include physical therapy, medications, and injections. The employee did not gain any significant functional improvement from conservative care. The employee was found to not be a surgical candidate by Dr.. The employee's psychological examination does reveal development of psychosocial sequelae that appears to be limiting the employee's function and recovery. The employee has also attended individual psychotherapy with positive responses noted. There is also evidence of physical deconditioning as FCE evaluation revealed the employee is unable to perform at a heavy physical demand level. As the clinical documentation provided indicates that the employee has undergone a sufficient multidisciplinary evaluation for the requested chronic pain management program, and the clinical documentation addresses concerns noted in the prior denial, the requested chronic pain management program would be considered medically necessary.

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

1. ***Official Disability Guidelines***, Online Version, Pain Chapter