

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: November 30, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Eighty hours of chronic pain management program.

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

FAMILY PRACTICE
PRACTICE OF OCCUPATIONAL MEDICINE

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Flahive, Odgen & Latson include:

- 11/22/10
- Notice of Disputed Issue(s) and Refusal to Pay Benefits, 04/15/10
- M.A., L.P.C., 10/13/10
- Coast Functional Testing, 10/14/10
- Pain & Recovery Clinic, 10/18/10, 10/19/10, 10/29/10
- Services Corporation, 10/21/10, 11/08/10

Medical records from the Provider include:

- D.C., 01/13/10, 01/20/10, 02/10/10, 02/18/10, 03/11/10, 03/26/10, 04/08/10, 04/16/10, 04/29/10, 06/03/10, 09/29/10, 10/27/10
- Diagnostic, 01/26/10
- M.D., 02/12/10, 02/19/10, 03/19/10, 04/28/10
- D.C., 02/18/10
- D.O., 03/11/10, 04/08/10, 04/22/10
- M.D., 04/05/10
- DWC-69, Report of Medical Evaluation, 06/14/10
- M.D., 05/14/10
- M.A., L.P.C., 10/13/10
- Functional Testing, 10/14/10
- Pain & Recovery Clinic 10/18/10, 10/29/10
- Texas Workers' Compensation Work Status Report, 11/15/10

PATIENT CLINICAL HISTORY:

The area of injury is cervical, right shoulder, and left shoulder. The date of injury is xx/xx/xx. At the current time, we are only approximately two weeks post injury. What is at issue would appear to be a referral for a comprehensive multidisciplinary pain program. This would seem premature at only two weeks post injury.

The history of the present illness was described on an initial medical report at Spine Rehabilitation Centers. The patient was struck by a mechanical gate on the left side at the nape of her neck and extending over the left shoulder to the acromioclavicular joint. There was concern for a clavicle fracture, which was not corroborated on further evaluation. It is noted that the patient was returned to modified duty; however, she reports that working in this capacity was affecting her ability to recover. She was having difficulty with activities of daily living as well. The diagnoses listed on the assessment of D.C., were left shoulder impingement and sprain/strain, cervical sprain/strain, and headaches. The patient's sensation was seen to be intact in the upper extremities. Her strength was graded at 5/5. There was limitation of left shoulder range of motion seen. She was alert and oriented without any evidence of cognitive impairment on the initial assessment of Dr. on January 13, 2010. There was an initial request for ten sessions over an eight-week period, which would be consistent with the ODG Guidelines.

In a follow-up visit from January 20, 2010, there was no change in the patient's physical examination. An MRI was requested for reasons that are not elucidated.

An MRI of the left shoulder revealed an increased signal in the distal rotator cuff tendon, with fluid in the subacromial/subdeltoid bursa suggestive of tendinopathy, with no definite evidence of a tear. There was a 1 cm subchondral cyst involving the humeral head, with slight surrounding edema. This was read by M.D.

There is a cervical spine MRI from January 26, 2010. The impression was degenerative changes of the disc at C5-6, with a diffuse 4 mm bulge, with associated posterior spondylotic spurs and evidence of bilateral uncovertebral hypertrophy. The above findings created a mild degree of spinal stenosis at this level. There was no evidence of neural foraminal compromise seen. The remaining levels were unremarkable.

There is a follow-up visit with Dr. on February 10, 2010. There was no change noted in the patient's evaluation. However, Dr. requested an EMG/nerve conduction study, despite a normal neurological assessment and no material change in her condition. There is no rationale discussed.

I have an assessment by, M.D. This is dated February 12, 2010. It is noted that the patient was prescribed medication; however, she did not pick it up. Despite shoulder pain noted to be 9 out of 10, she was not using pain medication for reasons that are not clear. She was reporting numbness in both hands, worse at night. The electrodiagnostic studies were seen to be pending at that point. The neurological assessment on the evaluation of February 12, 2010, was positive for carpal tunnel syndrome bilaterally; however, this is not an area of injury. The assessment was left shoulder acromioclavicular joint impingement and cervical radiculitis. The patient was seen to be taking Flector patch, muscle relaxants, and Naprosyn. Dr. recommended a follow up in one week. Dr. recommended physical therapy for improvement in the left shoulder symptoms, as well as a shoulder injection.

I have report of an electrodiagnostic study from Integrative Health & Medical. On physical examination, prior to the test, the patient was seen to have symmetrical reflexes of 1/4 in the biceps, triceps, and brachioradialis. Her vascular integrity was good. There was no obvious evidence of muscular atrophy. The skin temperature was within normal limits. The reported sensory testing revealed hypesthesia along the left C5, C6, and C8 dermatomes. The assessment was electrophysiological evidence most consistent with an active denervation/reinnervation process involving the left C8 and/or T1 nerves. There were findings consistent with a cervical sprain/strain and cervical radiculopathy. D.C., recommended flexion and extension views to establish stability of the cervical spine.

There is a pain management consultation from March 11, 2010, by D.O. The patient was seen for a follow-up visit. The patient's medications at that time included Vicodin, Zanaflex, and Relafen. Dr. recommended a cervical epidural steroid injection as a diagnostic and therapeutic maneuver.

There is a procedure note from April 5, 2010. There was a cervical epidural steroid injection performed by M.D. This was well tolerated without complications.

There is a follow-up visit with Dr. on April 8, 2010. The patient reported "some improvement."

There is a follow-up visit with Dr. on April 8, 2010. At that point, he stated that it was still too early three days post injection to determine full effectiveness, although I would not anticipate any change at that point. The patient reports a pain level of 10 out of 10 on the visual analog scale. Dr. recommended a follow up in 14 days for reassessment and possible second epidural steroid injection.

There is a follow-up visit from April 22, 2010. There was 60% improvement in the patient's overall symptoms from her previous pain level noted. The neurological assessment revealed intact cranial nerves. On assessment, she denied any paralysis, hyperesthesia, anesthesia, motor weakness, or headaches.

There is a follow-up visit with Dr. on April 28, 2010. He noted that there was slight diminished strength in the left supraspinatus, infraspinatus, and subscapularis graded at 4+/5. He noted that the neck revealed normal findings. No additional carpal tunnel syndrome symptoms were noted on neurological assessment. The carpal tunnel was seen to be positive on the right side, however, negative on the left side at the cubital and carpal tunnel. Two-point discrimination was seen to be normal throughout on the right side.

M.D., performed an impairment rating on the patient on May 14, 2010, and awarded her an 11% whole person impairment rating. The assessment was neck pain and contusion, cervical radiculitis, and shoulder sprain/strain. Based upon his assessment, Dr. did not anticipate any material change in her clinical condition, and therefore, the patient was at maximum medical improvement. The

patient was awarded a 5% for DRE Category II of the cervical spine and a 10% impairment of the left upper extremity, translating into a 6% whole person impairment rating for diminished range of motion of the shoulder on the left side.

Dr. released the patient in an unrestricted capacity as of June 3, 2010, agreeing with the designated doctor.

There is almost a four-month interval before the patient's next follow-up visit on September 29, 2010. She was requesting a return to work in the sedentary physical demand level because she could not function at her previous job. She was placed in a sedentary physical demand level with a 10-pound weightlifting restriction. The recommendation was for chronic pain management.

There was a work capacity evaluation performed on October 14, 2010. The patient was seen to have good validity profile and demonstrating maximal effort. She was only able to function within the sedentary physical demand level, which did not meet her previous job description of heavy.

There is a consultation from Pain & Recovery Clinic of on October 18, 2010. There were 80 hours of chronic pain management requested. The 80 hours were denied as neither reasonable nor necessary. This was appealed by Dr.

M.D., took the patient off work completely as of November 15, 2010.

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

I would have to uphold the previous adverse determination. All of the imaging studies to date have indicated areas of a chronic degenerative change, however, nothing that can be acutely and directly attributable to the work-related injury, which appears to involve blunt force trauma to the left shoulder and neck. The patient has previously been released by an evaluating physician in an unrestricted capacity, as he did not feel there was any medical etiology which would likely result in any material change in her condition.

According to the ODG for chronic pain management programs for neck injuries, there is far less data available to corroborate long-term efficacy, however, the results are felt to be similar to lumbar spine-type injuries. In any event, in my opinion, the etiology of her ongoing pain complaints is related to chronic degenerative osteoarthritis and rheumatoid arthritis. There is nothing that can be directly attributable to the mechanism of injury as described. The patient was previously released with a four-month hiatus. The etiology of her return is not quite temporally clear. There is discontinuity of care, which would not corroborate an occult and ongoing process.

In addition, there are several notations within the chart indicating that the patient has not taken her pain medications during the course of treatment, indicating either a lack of understanding or a lack of significant underlying necessity of pain medication requirement.

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
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)