



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 12/06/10

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: 10 sessions Chronic Pain Management Program (5 x per week, 8 hours per day x 2 weeks)

DATES OF SERVICE FROM 10/22/2010 to 11/05/2010

**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. 05/23/07 - CT Lumbosacral Spine
2. 07/17/07 - Procedure Report
3. 08/24/07 - Procedure Report
4. 07/22/08 - Procedure Report
5. 08/12/08 - Procedure Report
6. 11/18/08 - Lumbar Myelogram and CT
7. 02/17/09 - Designated Doctor Evaluation
8. 04/20/09 - Psychological Screening
9. 09/10/09 - Operative Report
10. 05/03/10 - Clinical Note - MD
11. 06/14/10 - Clinical Note - MD
12. 07/16/10 - Clinical Note - MD

- 13.08/02/10 - Patient Referral and Intake Form
- 14.08/09/10 - Psychological Evaluation
- 15.08/09/10 - Physical Performance Evaluation
- 16.08/09/10- BHI Report
- 17.08/10/10 - Medication Contract
- 18.09/30/10 - Pre-Certification Request
- 19.10/11/10 - Utilization Review
- 20.10/20/10 - Request for Appeal
- 21.10/26/10 - Utilization Review
22. **Official Disability Guidelines**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on when she picked up a box and felt severe pain to the low back.

A CT of the lumbosacral spine performed 05/23/07 demonstrated L5 to be transitional. There was left spondylolysis and sclerosis in the right pars at L5. Predominately central 5 mm disc herniations were present at L3-L4 and L4-L5, slightly asymmetric toward the left at L4-L5. The residual midsagittal spinal diameter was about 8 mm at L4-L5 and about 7 mm at L3-L4.

The employee underwent lumbar epidural steroid injection to the left at L4-L5 on 07/17/07 and 08/24/07.

The employee underwent lumbar epidural steroid injection to the left at L4-L5 on 07/22/08 and 08/12/08.

Lumbar myelogram and CT performed 11/18/08 demonstrated a transitional vertebra counted as L6. There were "dynamic" L4-L5 and L5-L6 disc herniations without demonstrated neural compression, although the L5-L6 herniation broadly abuted the adjacent descending roots sheaths.

The employee was seen for Designated Doctor Evaluation on 02/17/09. The employee complained of low back pain with numbness and tingling into the left lower extremity. The employee reported serious diminution of her activities of daily living. The employee previously received three lumbar epidural steroid injections which provided minimal relief. The heel walk and toe walk were negative for low back pain. There was hypoesthesia noted on the left side from the dermatome zones of L3, L4, L5, and S1 dermatomes. The remaining right L3 to S1 sensory dermatomes were within normal sensory perceptions. The deep tendon reflexes were normal bilaterally. There was palpatory evidence of joint fixations, articular, and segmental dysfunction in the lumbosacral-pelvic regions. The employee was assessed with lumbar intervertebral disc disorder without myelopathy and lumbago. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

The employee underwent a presurgical psychological screening on 04/20/09. The employee was felt to be a good candidate for surgical intervention.

The employee underwent bilateral laminectomy and foraminotomy of L4, L5, and L6, left L5-L6 discectomy, L5-L6 transforaminal interbody fusion with PEEK cage, L4-L6

posterior lateral fusion with autograft/allograft, and L4-L6 instrumentation with pedicle screws and rods on 09/10/09.

The employee saw Dr. on 05/03/10. The employee reported low back pain that radiated to the bilateral buttocks. Physical examination revealed full strength. Sensation was intact to light touch and pinprick. The employee ambulated with an antalgic gait. The employee was recommended for electrodiagnostic studies.

The employee saw Dr. on 06/14/10. The employee reported back pain that radiated to the buttocks. Physical examination revealed full strength. Sensation was intact to light touch and pinprick. The employee was advised to follow up in two weeks.

The employee saw Dr. on 07/16/10. The employee reported residual left leg pain. Physical examination revealed full motor strength. Sensation was intact to light touch and pinprick. The employee ambulated with an antalgic gait. The employee was referred for pain management.

The employee was seen for psychological evaluation on 08/09/10. The employee reported low back pain and pressure. The employee reported constant numbness from the left buttock to the calf. The employee described the pain as burning, sharp, shooting, stabbing, aching, cramps, and tender. The employee rated her average daily pain at 5 out of 10. Current medications included Norco, Flexeril, and Lyrica. The employee had no history of previous mental health treatment and no previous inpatient psychiatric hospitalization. The employee reported poor sleep quality. The employee reported weight loss of 100 pounds, increased appetite, dizziness, numbness, hot flushes, chills, paresthesia, and muscle tension. The employee avoided activities and places. The employee denied suicidal or homicidal ideations. The employee's BDI score was 11, indicating mild depression. The BAI score was 10, indicating mild anxiety. The employee was recommended for a chronic pain management program.

A BHI-2 Interpretive Report dated 08/09/10 reported a high level of self-discipline, emotional resilience and optimism, and a high level of workplace conflict and frustration. The report stated the employee disclosed an unusual absence of any psychological weakness. The report stated this could indicate that she was well-adjusted and untroubled or it could indicate a tendency to underreport information.

A Physical Performance Evaluation was performed on 08/09/10. The employee complained of lumbar pain that radiated to the left leg and foot. The employee rated the pain at 5 out of 10 on the visual analog scale. The pain worsened with prolonged activity. The employee's prior occupation as a machinist required a heavy physical demand level. The employee stated she was no longer employed. The employee's current calculated physical demand level was sedentary to light. The employee was recommended for ten days of a chronic pain management program.

The request for ten sessions chronic pain management program (5 x week, 8 hours per day x 2 weeks) was denied by utilization review on 10/11/10 due to the presence of negative indicators. The employee showed elevated scores on workplace conflict. Her high scores on the resilience scale did not support her need for additional treatment as per report “she is self disciplined, emotionally resilient, and prone to proactive conduct”. The employee was felt to be a better candidate for an alternative program that did not focus as much on emotional and psychological issues. Also, the employee had been disabled for over twenty-four months and a Functional Capacity Evaluation was not submitted for review.

An appeal letter dated 10/20/10 indicated the employee's BHI-2 shows the claimant probably felt resentment toward her employer, she may make demands for accommodations in the workplaces, and she may have conflicts with her supervisor. The employee was not a candidate for individual counseling as she had completed conservative psychological management previously.

The request for ten sessions of a chronic pain management program (5 x week, 8 hours per day x 2 weeks) was denied by utilization review on 10/26/10 due to the employee being disabled for more than 24 months. The employee is not currently working. There is no functional capacity evaluation submitted.

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

The clinical documentation provided for review does not support the requested chronic pain management program. The employee has been disabled longer than twenty-four months and guidelines indicate that chronic pain programs rarely allow return to work outcomes in employees with a continued disability for longer than twenty-four months. The employee does not exhibit any significant elevated depression scores that would reasonably benefit from a chronic pain program. There is also no indication of any significant functional limitations based on Physical Performance Evaluations.

As the clinical documentation does not meet guideline recommendations for the request, medical necessity is not supported.

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

*Official Disability Guidelines*, Online Version, Pain Chapter