



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
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: 01/27/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic Pain Management Program x 2 weeks; 80 hours

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

Board Certified Physical Medicine & Rehabilitation
Fellowship Trained Pain Management

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. Family clinical notes 11/20/07-07/21/09
2. Sports Medicine physical therapy notes 12/05/07-12/27/07; 6 visits
3. Authorization request for physical therapy 12/10/07
4. MRI of the lumbar spine 01/14/08
5. Sports Medicine physical therapy notes 02/13/08, indicating completion of 17 visits and 07/23/08-08/20/08 of 6 visits
6. Neurologist consult 03/17/08-05/27/08
7. request for CT myelogram 03/20/08
8. request for EMG/NCV with SSEP 04/09/08
9. IME 06/25/08, MD
10. Chest x-ray report 06/26/08, 06/27/08, 2 view chest x-ray 07/01/08 and 07/02/08
11. CT scan of the chest 06/30/08
12. request for epidural steroid injection 09/02/08
13. request for epidural steroid injection appeal 09/25/08
14. Report of medical evaluation by MD 04/08/09

15. Designated doctor's evaluation by Dr. MD 07/15/09
16. Psychological evaluation 09/04/09
17. Functional capacity evaluation 09/04/09
18. Pain management consultation and subsequent office notes 09/08/09-12/08/09 by MD
19. Worker's Compensation claim notes 09/16/09
20. Utilization review notes 10/19/09 requesting pain management for 10 days
21. Utilization review notes 11/12/09 upholding denial of chronic pain management for 10 days
22. Report of medical evaluation 11/17/09 by MD
23. Utilization review notes 12/07/09 and 12/16/09 regarding pain management
24. Peer to peer with Dr., 12/21/09
25. Final handwritten clinical note 01/06/10 from pain management
26. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who presented to his family medical clinic for a work related injury. The employee initially presented to the emergency room due to pain in his lower back (The date of injury as provided by the carrier indicates xx/xx/xx; the clinical notes indicate xx/xx/xx or xx/xx/xx.)

On 11/20/07, at the family physician's office, the employee weighed pounds, had no evidence of radicular symptoms by examination, and was treated conservatively with rest, stretching, and anti-inflammatory medications. In follow up the employee indicated he had missed three days of work due to pain and had an inability to stand longer than twenty to thirty minutes. His weight had increased in one week by 7 pounds. He was dispensed oral Prednisone for his symptoms.

On 12/05/07-12/27/07, the employee underwent physical therapy.

Family clinical note on 12/11/07 indicated that the employee gained an additional 7 pounds.

On 12/27/07, the employee felt that the physical therapy was helping, but that the relief did not last long.

On 01/14/08, the employee underwent an MRI of the lumbar spine which showed mild degenerative change at L4-L5. There were no disc herniations and no neural impingement identified. There were some degenerative facet changes at L4-L5 and L5-S1.

On 01/23/08, in follow up with a family physician, his weight was stable at pounds, and he was recommended to see a neurosurgeon.

On 02/13/08, upon discharge from therapy after seventeen visits, the employee felt that the therapy helped to decrease the pain, but after sitting for prolonged periods, the pain radiated down his lower extremities.

On 02/19/08 in follow up with his family physician, his weight had increased to pounds. He continued to have no evidence of objective radiculopathy on examination.

On 03/17/08, the employee saw neurologist, Dr. who recommended an EMG/NCV and a lumbar myelogram with CT. He recommended continuing therapy and certified that the employee was unable to work.

On 04/14/08, the employee followed up with Dr. who disagreed with a peer to peer for denial of the EMG. He felt that the employee did have radiculopathy on examination and felt that he had problems on his lumbar MRI from L3-S1.

On 04/16/08 in follow up with family physician, the employee was pounds. He was continued on Lodine with no evidence of radicular symptoms by Dr. examination.

On 06/03/08, the employee was pounds and was continued on medications. He was set up for a required medical evaluation.

On 06/25/08, the employee saw Dr. who opined that the employee had signs and symptoms consistent with a sprain/strain of the lumbar spine. On examination he could not find any objective evidence of radiculopathy. He agreed with the denial of the lumbar myelogram and CT scan as well as no indications for EMG/NCV study. He felt that because the employee had some good response to therapy, although not lasting, that additional therapy would be beneficial.

On 06/26/08, the employee had a two day history of respiratory distress and was seen at Health Systems. X-ray revealed interstitial edema. Follow up films revealed right upper lobe atelectasis vs. infection/inflammation. CT scan of the chest revealed no evidence of a pulmonary embolism and a probable infectious small airway disease. The right upper lobe had interstitial infiltrate or sub-segmental atelectasis.

By 07/02/08, the prominent interstitial pattern was again noted in which could possibly indicate asthma, bronchitis, or cigarette smoking history.

07/23/08-08/20/08 the employee participated in physical therapy at Sports Medicine for six sessions.

On 09/02/08, a request for an epidural steroid injection from Dr. was denied.

On 09/16/08 in follow up with his family doctor, the employee was pounds. He continued with back ache and complaints of pain down both legs. There was no objective evidence of radiculopathy.

On 10/14/08, the primary care provided placed the employee on Meloxicam. And on 01/13/09, he discontinued the Meloxicam and dispensed Tramadol.

On 04/08/09 the employee saw, MD who opined that the employee was not at Maximum Medical Improvement (MMI). She found on examination that the employee did have a positive seated straight leg raise test on both lower extremities with 4/5 strength of the extensor hallucis longus on the right compared to 5/5 on the left.

Sensory examination revealed decreased sensation over the L5-S1 distribution of the foot on the right. On the left, there was decreased sharp touch sensation in all distributions around the ankle. She opined that the employee would not be able to return to work primarily due to extreme dyspnea and recommended more therapy as he did derive benefit in the past.

On 07/15/09, the employee underwent a Designated Doctor's Evaluation with Dr.. Again, Dr. found on examination, normal sensation in the lower extremities and negative straight leg raise testing with normal extensor hallucis longus strength. He opined that the employee had reached MMI as of 07/15/09 with a 5% whole person impairment. He further opined that the employee should be capable of sedentary to light work activities. He indicated that the employee was grossly deconditioned and overweight.

On 07/21/09, the employee followed up with his family physician. At that visit, he weighed pounds and was prescribed Soma for his symptoms.

On 08/05/09, the employee began seeing MD for pain management. The history indicated that the employee had signs of depression and confirmed a 100 pound weight gain since the injury. The employee participated in the pain management program including psychological screening and diagnostic interview on 09/04/09. He underwent a Functional Capacity Evaluation (FCE) on 09/04/09 which indicated the employee could lift 30 pounds on an occasional basis, and carry 20 pounds on an occasional basis. Work hardening was recommended. Psychological evaluation indicated depressive disorder, anxiety disorder, and pain disorder. Recommendation was for behavioral intervention as well as a work hardening program. On 09/10/09 notes from Dr. indicated that the employee was released to light duty. Nurse case manager notes indicate he was offered light duty four hours a day doing desk work. On 09/14/09 a note indicates the employee was only at work for twenty minutes and had to be sent home due to a flare up of his back pain.

On 09/23/09, nurse case manager notes indicated the employee went back to work and could not tolerate sitting in a plastic chair for an hour and a half. He was returned to work driving a motorized scooter with similar problems.

On 10/29/09, the employee was utilizing Soma and Hydrocodone for his symptoms by Dr. .

Reported medical evaluation on 11/17/09 by, basically reviewed the treatment and documented the previous information from the Designated Doctor Evaluation and agreed that the employee was at MMI and a 5% whole person impairment.

On 12/08/09, the employee was pounds, he was continued on the same medication and request was made for pain management program continuation.

On 12/21/09, peer review with Dr. and Dr. was denied indicating that the employee was currently at a light to medium physical demand level and due to inconsistent presentation with little improvement, the need for a chronic pain management program was not supported.

On 12/07/09, a request for chronic pain management for two weeks over eighty hours by Dr. PhD was denied, as the employee was significantly overweight, has confounding problems, and psychological symptoms related to stress, are mild to normal.

On 12/21/09, Dr. in peer to peer with Dr. indicated that the employee was not motivated towards recovery and that was also evident from the records. The peer to peer indicated that the use of Hydrocodone and Soma were not indicated or justified and appeared to be part of ineffective treatment perpetuated at the clinic.

The last clinical note of 01/06/10 indicated the employee was continuing on Hydrocodone and Soma without any significant change in examination.

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

Agreement is made with the previous reviewers. The employee is morbidly obese and suffers from exertional dyspnea which interferes with his ability to work more so than the injury of 11/15/07. The employee had a lumbar sprain and strain and was found to be at MMI and was granted a 5% whole person impairment on 07/15/09. The employee has been seen in a pain management clinic for some time without any evidence of functional improvement. The continuation in that program is not supported by the guidelines. The previous FCE through the pain management clinic indicates the employee is able to perform a sedentary to light physical demand level.

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

1. Jensen I, Harms-Ringdahl K. Strategies for prevention and management of musculoskeletal conditions. Neck pain. *Best Pract Res Clin Rheumatol.* 2007;21:93-108.
2. Laxmaiah Manchikanti, MD, Vijay Singh, MD, David Kloth, MD, Curtis W. Slipman, MD, Joseph F. Jasper, MD, Andrea M. Trescot, MD, Kenneth G. Varley, MD, Sairam L. Atluri, MD, Carlos Giron, MD, Mary Jo Curran, MD, Jose Rivera, MD, A. Ghafoor Baha, MD, Cyrus E. Bakhit, MD and Merrill W. Reuter, MD. American Society of Interventional Pain Physicians Practice Guidelines. *Pain Physician*, Volume 4, Number 1, pp 24-98, 2001.
3. Theodore Doege, MD, Thomas Houston, MD, et.al. The American Medical Association Guidelines to the Evaluation of Permanent Impairment, 4th edition, 4th printing; October 1999.
4. **Official Disability Guidelines**