INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
REVISED REPORT
Injured worker omitted from initial letter of 06/22/10

DATE OF REVIEW: 06/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Ten sessions of a chronic pain management program

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.O., duly licensed physician in the State of Texas, fellowship-trained in Pain Management, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over 23 years of active and current practice of Pain Management

REVIEW OUTCOME:
Upon independent review, I find that the previous adverse determination or determinations should be:

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
722.73	*97799*		*Prosp.*						*Upheld*

INFORMATION PROVIDED FOR REVIEW:
1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letter of denial 04/13/10 and 05/07/10, including evaluation and criteria used in denial.
4. Basic Interpretive Report 02/05/10.
5. Rehabilitation evaluations 04/08/10 and 04/23/10.
6. Physical therapy evaluation 02/04/10.
7. Orthopedic surgeon evaluation 04/15/09 and addendum 06/08/09.
8. Injection visit note 02/16/10.
9. Independent Medical Evaluation 10/14/09.
10. EMG/NCV 04/14/09.
11. Operative note 07/09/08, procedure note and discharge summary 03/05/09.
12. Chronic pain program progress notes 06/04, 06/11 & 06/13/08.
13. Radiology reports 02/13/08, 02/04/08 & 01/14/10.
14. Family medicine progress notes 01/26/08 - 01/05/10

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This claimant suffered a slip-and-fall injury on xx/xx/xx, landing on her buttock. She had a surgical history of lumbar laminectomy predating the injury by several years. On xx/xx/xx, approximately three weeks

after this alleged work injury, cervical MRI scan was performed, demonstrating C5/C6 and C6/C7 spondylosis with mild canal stenosis and facet joint spurring with bilateral foraminal stenosis at both levels. Lumbar MRI scan on that same date noted that the procedure was performed without contrast. It demonstrated "abnormal material" continuous with the L4/L5 disc margin on the left, which "cannot be differentiated on this study if this is scar or disc material." MRI scan of the left shoulder was also performed on that date, demonstrating acromioclavicular arthritis and supraspinatus tendinopathy.

The claimant then had two sessions of individual psychotherapy on 06/04/08 and 06/12/08 at which time it was noted that her Beck Depression Inventory score reduced from 36 to 25 and her Beck Anxiety Inventory reduced from 38 to 14. Her pain level, however, remained at a constant 8/10.

Anterior cervical discectomy, corpectomy, and instrumented anterior fusion at C5/C6 and C6/C7 was performed on 07/09/08. A caudal epidural steroid injection was performed on 03/05/09.

Follow up on 03/13/09 notied no improvement in pain. Physical examination documented nonspecific abnormality and pain due to lumbar spine flexion or extension and a nonspecific right straight leg raising test. Also noted was abnormal heel-toe walking and limping, although the affect was said to be "normal."

On 04/14/09 a chiropractor performed EMG/NCV studies. He stated that the claimant had undergone cervical spine surgery in 2006, which was clearly not correct, as well as lumbar spine surgery on 07/17/08 consisting of left L3/L4 laminectomy and discectomy, which was also incorrect. The findings of the chiropractor's test were of moderate right L4/L5 and radiculopathy and mild left L5 radiculopathy with recommendation for urologic evaluation for urinary incontinence and for MRI scan with contrast.

On 04/15/09, an orthopedic surgeon, performed an Independent Medical Examination of the claimant. In that evaluation he reviewed all the claimant's studies to date including an EMG/NCV study on 03/10/08, demonstrating no electrodiagnostic evidence of cervical or thoracic radiculopathy. He also noted the claimant having undergone anterior cervical discectomy and fusion at C5/C6 and C6/C7 as well as at T1/T2. The claimant complained of nonspecified arm and leg numbness and of nonspecified arm, neck, lower back, hip, and leg weakness. Physical examination, however, noted no cervical spasm and no atrophy of the upper back muscles. Cervical range of motion was significantly decreased by over 50% in all ranges of motion. Muscle strength, however, was essentially normal bilaterally. Grip and pinch strength on the left were almost nonexistent. However, there was no evidence of spasticity or rigidity, and the reflexes in the upper extremities were entirely normal. Lumbar exam revealed nonspecific tenderness of the paraspinous muscles with pain on axial compression. The seated straight leg raising test was negative bilaterally but positive bilaterally in the supine position at 45 degrees. Sensation was nonspecifically decreased in the right leg, but reflexes of the knees and ankles were entirely normal. Lumbar range of motion was decreased in all planes, and there was "make/break right ankle weakness." In addition, seven out of seven Waddell's signs were positive. The surgeon, however, stated the claimant was not at MMI, recommending repeat MRI scan and electrodiagnostic studies.

On 06/05/09 the surgeon clarified his opinion after being told that the claimant's extent of injury included only cervical pain and left upper extremity radiculopathy and lumbar strain. He changed his opinion based on this information, stating the claimant was at MMI with a 5% whole person impairment rating.

Independent Medical Examination was then performed on 10/14/09. The examiner severely criticized the chiropractic electrodiagnostic studies that were performed, stating that the conclusions were not supported nor valid. He questioned the chiropractor's ability to perform such a test accurately and stated that his review of the raw data demonstrated no evidence of any radiculopathy. He further questioned the "reliability and validity" of the chiropractor's electrodiagnostic studies. He also reviewed a lumbar MRI scan from 07/03/09, which apparently revealed the previous L4/L5 operative changes with multilevel multifactorial degenerative changes but no disc herniation and no significant foraminal stenosis or neural impingement. He stated this contradicted the chiropractor's EMG conclusions. He stated the claimant had persistent neck and shoulder pain with back pain, right hip pain, and weakness, fatigue, and numbness in

the right leg and left arm. He also noted the claimant's complaint of bladder incontinence and her pain level of 7-8/10 "on a good day." He noted the claimant had undergone several epidural steroid injections of the neck and low back with minimal to no relief and was on no medication, "since she does not like to take medications." He stated there was no pathology on clinical exam of the left shoulder to explain the claimant's self-limitation in left shoulder range of motion, noting the MRI scan failed to reveal any evidence of rotator cuff tear or impingement. He also stated the claimant had a "lumbar strain" superimposed on pre-existing spondylosis with "no evidence of disc herniation or lumbosacral radiculopathy." He further stated that there was no evidence of acute injury to lumbar spine structures and no pathology on the MRI scan for raw data of the EMG to support the claimant's subjective complaints of "urinary incontinence." He found no reason or necessity for any further chiropractic followup and recommended consideration of a chronic pain management program, using the response to the first ten sessions to determine the subsequent ten sessions necessity. He noted the claimant did not wish to take medication. Finally, he stated there was no evidence of cervical radiculopathy or lumbar radiculopathy and no indication of neurogenic bladder.

The claimant then followed up with Dr. several times between October 2009 and January 2010. Only one physical examination was documented on 01/05/10, demonstrating moderate lumbar muscle hypertonicity.

On 01/14/10 L4/L5 lumbar fusion with instrumentation was recommended.

On 02/05/10 the claimant underwent BHI-2 testing. It was noted, "This patient did not answer all of the items on the Pain Complaints, Depression, and Borderline Scales" and that she "did not endorse any of the validity items." Under the section entitled "Treatment Recommendations," it was noted on the test that the claimant's results "suggest that she may have exaggerated the negative aspects of her life" and that she had "broad preoccupation with illness symptoms." Recommendation was made for "psychopharmacologic treatment for depression." Also noted was the claimant's endorsement of one or more items "suggesting a history of abuse or trauma." Finally, it was noted that the analysis of the DHI-2 test was "generated by a computer analysis."

On 02/04/10 a psychologist, also evaluated the claimant. He noted the claimant's dislike and rare use of medication and her pain level of 9/10 "100% of the time." He also noted the claimant's complaint of "moderate to severe fatigue 100% of the time." The only psychologic testing performed was a Beck Depression Inventory with a score of 41 and a Beck Anxiety Inventory with a score of 39, both worse than after she had participated in individual psychotherapy some twenty months before. The psychologist recommended the claimant attend twenty sessions of the chronic pain management program which employed him.

On 02/04/10 the chiropractor evaluated the claimant for a "physical performance evaluation." The results indicated the claimant was "neurologically intact" with "hypersensitivity" of the left L5/S1 dermatomes. Knee and ankle reflexes were normal and symmetric. There was absolutely no cardiovascular or hemodynamic data documented to indicate whether the claimant put forth any effort or, for that matter, demonstrated any valid evidence of anything. In fact, the rapid exchange grip tests indicated the claimant gave "invalid efforts" despite the fact that there was no evidence of injury to the claimant's hands. The chiropractor, like the psychologist before him, recommended the claimant attend ten sessions of the chronic pain management program that employed them both.

On 04/08/10 a psychologist recommended the claimant attend ten days of the chronic pain management program eight hours per day. Among the criteria he cited to support this request was the claimant having "no history of previous mental health treatment" despite the fact that this was clearly incorrect. He also cited ODG criteria indicating that a chronic pain management program could be considered "in the absence of other options likely to result in significant clinical improvement." Specifically, he cited criteria stating that "underlying non-work related pathology that contributes to the pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment" and that "psychologic testing using a validated instrument" be done to identify "pertinent areas" that needed

addressing in the chronic pain management program. Neither of these criteria had been met. Initial request for preauthorization was denied on 04/13/10, citing ODG criteria and the reviewer's opinion that even if the claimant "does not want to take opioid narcotics, there are numerous other medications that can be given to provide relief in her pain," and that there was a "question of whether she is going to have back surgery."

An appeal letter was then submitted by the chronic pain management program, now stating that the claimant had undergone previous psychologic treatment, even though that had previously been stated as not occurring. The letter then merely went on to re-cite all the same ODG criteria as the initial request. A second, different physician adviser recommended nonauthorization of the chronic pain management program on 05/07/10, again citing ODG criteria.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

Both physician advisers appropriately cited appropriate ODG criteria in recommending nonauthorization of the requested ten sessions of a chronic pain management program. Upon review of their analyses, I find no reason to disagree with the opinions they documented and criteria they cited. There is, as documented, still a recommendation for L4/L5 lumbar fusion. Even if the condition for which this fusion is performed is not related to the work injury, which appears to be nothing more than a lumbar strain as far as the low back area is concerned, there is absolutely no medical reason, necessity, or logic in having a patient participate in the chronic pain management program when there is still proposed invasive surgery documented for her ongoing pain complaints. ODG criteria clearly state that a chronic pain management program is not medically reasonable or necessary unless all treatment options have been exhausted, including even treatment of non-related medical conditions. Secondly, this claimant has not had valid psychologic testing as recommended by ODG criteria, nor any valid functional testing to determine what her physical capacities actually are. The tests performed by the chiropractor contained no documentation regarding cardiovascular or hemodynamic criteria that would otherwise have provided demonstration of this claimant putting forth valid effort in performing the tests. Since the claimant's test results were so far out of the norm, the absence of this cardiovascular and hemodynamic data, in my opinion, completely invalidates whatever unsupported conclusions chiropractor Hill made. The magnitude of this likely invalid study is made even greater in light of the Independent Medical Examination performed by Dr. Mitchell in which the claimant manifested seven out of seven positive Waddell's signs. Finally, as one of the physician reviewers pointed out, there are numerous medications that can be provided for the treatment of chronic pain and the claimant's alleged severe depression that have not been adequately explored or trialed. It is certainly the prerogative of the claimant to refuse taking these medications, but without adequate trial of these medications, it cannot be said that all appropriate treatment options have been exhausted. Therefore, for all of the above reasons, the request for ten sessions of a chronic pain management program has been appropriately, in my opinion, evaluated and denied by the two prior physician reviewers, and their recommendations for non-authorization are, therefore, upheld. There is no medical reason or necessity, therefore, for the requested ten sessions of a chronic pain management program according to ODG Treatment Guidelines and nationally accepted medical standards of care.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)