

**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:** March 23, 2011

**IRO CASE #:**

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

Physical medicine procedure. Ten sessions of Chronic Pain Program. CPT Codes: 97799.

**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**

**PATIENT CLINICAL HISTORY:**

I have an evaluation at medical clinic. Examiner was Ed.D., psychologist. He reviewed the patient's medical records. She had been working for two years at her place of employment as an employee. She sat in a chair that broke. The patient was taken to a Hospital. Her foot was cast and her back examined. At the current time we are more than ten years post injury. , is the date of injury. She is currently undergoing chronic pain management.

Initial x-rays of the left ankle and lumbar spine revealed no fracture. MRI revealed L2-L3 nerve root impingement. EMG's were described as abnormal. The patient underwent a trial of a spinal cord stimulator and had undergone five lumbar sympathetic block injections and physical therapy, which reportedly made her pain worse. Medications at the time of her exam included Celebrex, Norco, Wellbutrin, and Neurontin. Comorbid psychiatric problems include bipolar illness. Beck Anxiety and Depression Inventories include mild levels of anxiety and depression. It was recommended the patient enter into an interdisciplinary chronic pain management program. Long-term and short-term goals for recovery were set, Ed.D., reporting.

The patient was seen to be functioning within the U.S. Department of Labor's medium physical demand level at the time of this Physical Performance Evaluation on October 22, 20XX. It was noted that the patient had not worked in her previous position since approximately the time of injury,

D.O., performed an examination on January 25, 20XX. It was noted the patient was undergoing chronic pain management at that time. She was seen to have full range of motion of the bilateral feet and ankles, approximately 5/5 strength or slightly less than 5/5, symmetrical bilateral lower extremity strength, 2/4 reflexes equal and symmetrical, no sensory deficits appreciated. There is no evidence of any type of focal neurological deficits. She was seen to be attending interactive group therapy, but it was related that she had anxiety and fear.

Working diagnosis as of January 31, 20XX, Dr. reporting, included a diagnosis of reflex sympathetic dystrophy of the lower limb. However, the physical examination findings would not corroborate ongoing

complex regional pain syndrome. There was no notation of any atrophy, cyanosis, focal neurological deficits, or dysfunction. Strength was described as 5/5 and the patient was seen to be neurologically intact without any evidence of allodynia or hyperesthesia. However, progress within the chronic pain management program was described as good. It was noted that the treating physician, Dr., was working to take the patient off of her Norco and titrate her to non narcotic analgesics, which in my opinion is very reasonable. It was noted that she completed ten days of chronic pain management as of February 10, 20XX, but her pain levels were seen to have remained elevated.

I have a utilization review note indicating the patient's progress appeared to be quite static in pain management. Her pain complaints appeared to be elevated, and there did not appear to be any progress in her psychological functioning or reduction in her medications. She was seen to be at her required physical demand level of medium. It was noted the patient had missed some sessions of her pain management program due to conflicts with her education program and severe weather. She was working on her MBA. It was felt by Ph.D. that if the patient could not commit to the program, there was no utility in continuing it.

Dr. stated that since duration of the patient's disability from 20XX she had shown great progress in pain management toward the attainment of her goals and that her care was reasonable and necessary, although the rationale for her lack of progress in ten years was not elucidated. An additional ten sessions of pain management were denied as there did not appear to be evidence of clinical progress. The evaluating review notes that the patient's Beck Depression Inventory and her Beck Anxiety Inventory were unchanged after nine sessions of pain management, which would not corroborate progress within a pain management program. The patient's GAF scale was also unchanged at 48. Minimal improvements were seen in dynamic lifting ability and no change in carrying ability. It was therefore felt that additional sessions were neither reasonable nor necessary as the patient's progress appeared to be static. This is certainly consistent with the OD Guidelines which recommend initial ten sessions of chronic pain management with additional sessions predicated upon objective evidence of improvement up to 20 sessions.

Ph.D., psychologist, did not feel that there was enough evidence of improvement to certify an additional ten sessions of chronic pain management. Consultation was on March 4, 20XX. Additional corroborating documentation is as previously described. Ph.D., Doctor of education, psychologist, recommended a trial of a spinal cord stimulator, diagnosis of chronic pain disorder. Date of evaluation was September 11, 20XX.

Dr. diagnosis as of December 2, 20XX, was complex regional pain syndrome, although how this was determined is not clear in the records. He describes none of the stigmata of complex regional pain disorder which might include hyperhidrosis, allodynia, hyperesthesia, cyanosis, or atrophy of the extremities. December 30, 20XX notes are similar "no neurosensory deficits noted in the bilateral lower extremities, reflexes were symmetrical at 2+/-4 and lower extremity strength was 5/5." There were no signs of complex regional pain syndrome. Serial physical examinations by Dr. were similar. They indicated no objective evidence of complex regional pain syndrome, only subjective complaints of pain. Dr. also noted that the patient had an inconsistent urine screen on June 25, 20XX, that was positive for Morphine and Codeine, which were not prescribed medications.

I have no further documentation.

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

I am asked if ten sessions of chronic pain management are reasonable or necessary. I would have to uphold the previous determination. I cannot see the utility of additional pain management. The patient's complaints appear to be completely subjective and highly variable. There is no objective evidence on serial physical examination throughout the entirety of 20XX to indicate any ongoing process such as complex regional pain syndrome. Initial injuries reported no fracture of the ankle or back. The patient has reported that her back symptoms have completely resolved. She is reported to have normal range of motion, no neurological deficits, symmetrical reflex, normal strength, and functioning within the U.S.

Department of Labor's medium physical demand level. Progress with an initial nine sessions of chronic pain management have resulted in very little improvement in the patient's anxiety scores or her depression scores. As such, the utility of additional pain management resulting in any material change is very low. As such, I cannot corroborate that this will yield any material change in the patient's clinical condition. In addition we are more than x years out from an initial injury. I cannot state at this point there would be any utility so far removed from the initial injury as far as functional recovery is concerned. There would be no anticipation for material change in the patient's condition.

**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)