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**Notice of Independent Review Decision
Amended Report of 8/8/11**

DATE OF REVIEW: 8/5/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 80 hours of chronic pain management (10 sessions 3x per week).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 80 hours of chronic pain management(10 sessions 3x per week).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: The patient, Rehab.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from the patient: 5/18/11 abdominal CT report.

N. TX Rehab: 5/17/11 evaluation by LPC.

: 6/20/11 denial letter, 7/16/11 denial letter, office notes by MD from 7/23/07 to 9/17/07, 9/7/05 medical policy sheet, 4/29/09 preauth request, 4/9/09 to 4/26/11 progress notes by, 8/5/10 preauth request, 8/4/10 therapy request form, 8/4/10 PT initial report, undated letter by, LPC, 10/28/08 report by, MD, 5/17/11 PPE report, 9/1/09 phone log report, 4/26/11 physicians injury report and 4/15/08 to 6/26/08 physician notes from Clinic.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when her feet became tangled in an electrical cord, causing her to fall. She received conservative treatment and was eventually able to return to work in July 2006. According to outpatient follow up records the worker has had chronic lower back pain.

According to Dr. who saw the worker for a required medical examination October 28, 2008 the worker reported that she was functioning reasonably well and working without any significant problems. She stated that she still had chronic low back pain that occasionally radiated into both lower extremities. She denied any numbness or tingling in the lower extremities. Dr. diagnosed lumbar spondylosis with chronic pain.

On the clinical note from Medical Group dated 2/10/11 the worker reported continuing pain that is bearable, 4/10 with Mobic. She was able to work three days per week for seven hours each day but still had pain. Handwritten notes on the examination form documented tenderness to palpation over the lumbar spine up to the thoracic spine paravertebral muscles, and decreased range of motion with guarding.

On April 26, 2011 the worker reported that she was doing well, was still working. She could perform some ADLs but was having difficulty with others. The physical exam form noted back pain on flexion greater than 30° or extension greater than 10°. Deep tendon reflexes were 2+. Strength was reported to be 5/5. The clinical diagnosis was lumbago, chronic stable pain. The treatment plan was to continue nonsteroidal anti-inflammatory medication, with follow-up PRN. The healthcare provider submitted a Report of Injury with a diagnosis of low back pain, 724.2, recurrence/aggravation of a pre-existing condition. The medications prescribed were Skelaxin and Mobic. Work limitations were prescribed, including limiting work to three times per week, seven hours per day, with a 30 minute break and lunch. Bending, stooping, kneeling and crawling were prohibited. Limitations were imposed regarding twists, squat/crouch, and stair/ladder climbing.

On May 17, 2011 the worker was seen for psychological evaluation, requested by Dr.. The worker stated that she was currently working 6 1/2 hours per day three days per week. The reported average daily pain was 4/10. The evaluator recommended a chronic pain management program.

A physical performance evaluation was performed May 17, 2011. Pain increased during walking, sitting and standing. Pain limited participation in reaching, stooping, squatting, crouching, crawling, kneeling, and balance. The worker did not participate in the cardiovascular evaluation due to pain. Lifting performance was in the sedentary category, with moderate pain. The evaluative summary concluded with a recommendation for chronic pain management.

On May 18, 2011 CT of the abdomen May 18, 2011 was performed. The listed reason for the scan was "kidney pain". Regarding the osseous structures visible on the abdominal CT scan, the radiologist reported the following:

There are multiple spurs present in the lower thoracic upper lumbar region, facet arthropathy in the lower lumbar spine, degenerative disc findings at L3-L4, L2-L3 facet arthropathy in the lower thoracic spine. At the T10-T 11 region there is a lobulated mass extending from the spinal canal to the right widening the foramina, measuring approximately 2.5 cm x 1.5 cm...slight enlargement since prior examination.

The radiology report included an incidental finding within the lower thoracic spinal canal on the right, interpreted to be an apparent area of dural ectasia or perineural cyst formation... "Cannot definitely exclude, but doubt neural-based solid neoplasm with slight increasing size from prior examination at the lower thoracic level as well as apparent Tarlov cyst within the sacrum.

An unsigned handwritten annotation was added to the radiology report stating the following: "my concern is that the perineural cyst that has slight increase in size which may be causing back pain". Recommendation was made for clarification of the enlarging presumed simple cystic structure in the left kidney with MR imaging as well as clarification of the expanding presumed perineural cyst in the lower thoracic spine on the right. MRI was recommended as the best choice for evaluation.

A request was submitted for 80 hours of chronic pain management. The requested treatment program was non-authorized. The non-authorization was upheld on appeal. The request was submitted for an independent review.

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

The clinical note of xx/xx/x stated that the worker was "doing well" and was still working. The worker was released to work with restrictions, with a diagnosis of lumbago, chronic stable pain. According to the Report of Injury submitted, the diagnosis was low back pain, 724.2, recurrent/aggravation of a pre-existing condition.

Pain was the limiting factor in the physical performance evaluation. Pain prevented the worker from participating in the cardiovascular evaluation. Therefore, no information about the cardiovascular status could be obtained from the physical performance evaluation.

Kidney pain was listed as the reason for the CT scan of the abdomen which was performed May 18, 2011. Based upon the radiology report of the findings from that CT scan, a recommendation was made for further evaluation of an expanding mass in the thoracic spine. The handwritten annotation mentioned that there was some concern that the mass may be causing back pain.

According to the ODG –TWC Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updated 07/15/11) pertaining to Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances...:

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:
(a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment.

The records submitted for this review do not include any mention of a follow-up MRI or other medical evaluation, if any, for further evaluation/clarification of the findings on the CT of the abdomen evaluation/clarification of the undetermined cardiovascular status. The ODG guidelines clearly state that underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated prior to or coincident to starting treatment. All criteria are not met according to the records provided. Therefore, the requested service is not medically necessary at this time.

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)