

Notice of Independent Review Decision
PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/1/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

160 Hours (20 sessions) of chronic pain management for the lumbar spine

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain
Management

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

160 Hours (20 sessions) of chronic pain management for the lumbar spine Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee's first report of injury or illness: A male with reported injury on xx/xx/xx. There are complaints of hip pain and the left lower extremity. There is a reported history of low back pain on treatment note review. The injured employee is status post formalized physical therapy and psychotherapy. Discussion regarding past treatment including recommendations of epidural steroid injection to the lumbosacral spine but this really was never performed. No reported documentation of this surgical consult was performed to assess any potential need of surgical intervention to the lumbosacral spine. In the course of treatment he was placed on activity restrictions including work restrictions but reportedly was considered capable of return back to work with restrictions signifying lack of findings of significant functional deficit. Injured employee has been utilizing Ultracet for attempted pain control while undergoing behavioral/psychological counseling. Injured employee reportedly was diagnosed with axis I pain disorder associated with both psychological and general medical condition; axis IV moderate to severe; axis V 55, prognosis was good.

Healthcare providers:

1. Bodies in Balance treatment note, 01/05/2011: Chronic low back pain complaints including symptoms to the anterior thigh. Injured employee reports onset of pain on 01/15/01. Examination findings reveal left hip range of motion deficits as well as lumbar spine range of motion deficits. Impression was lumbar intervertebral disc pathology

with myalgia and myositis unspecified.

2. Letter by treating physician, 12/29/10: Reported that orthopedic consult was made with no recommendations of surgery. Discussion made regarding lumbar area was not a compensable injury; therefore, epidural steroid injection was not processed or performed.

3. Treatment note, 12/08/10: Reported his pain complaints of the hip were improving. Voltaren was providing benefit.

4. Reported history, 09/16/03: Left hip avascular necrosis status post left hip replacement with metal-on-metal ball-and-socket with uncemented Mallory femoral stem.

5. Psychological counseling treatment note, 11/08/10: Reported Mode of Injury: Injured worker fell on xx/xx/xx from a ladder falling approximately 10 feet with left hip pain, low back pain. Discussion made regarding his past hip replacement in September 2003 but he had persistent pain since the surgery. Reportedly underwent physical therapy with no benefit.

6. Functional capacity evaluation, 08/18/10: Reported light PDO physical capacity with job requirements of heavy.

7. Designated doctor evaluation, 04/21/03: Indicating he had reached statutory MMI of 01/20/03 but required a surgical reevaluation of the hip.

8. Muscle testing and range of motion testing, date not given: Findings of mild left hip range of motion deficits and mild range of motion lumbar spine deficits. Strength: Weakness noted to the left hip as well as the hamstrings.

9. Kinetic Clinic, treatment notes:

a. 09/07/10: Reported slow improvement with his treatment with conservative care with ongoing mild range of motion deficits of the hip, left lower extremity as well as low back.

b. 09/15/10: Reported recommendations of work conditioning program over work hardening program. There is no reported need of psychological services on that assessment.

10. Treatment note, 06/16/10: Reported a functional capacity evaluation of 03/31/10 indicating a medium physical demand level. He underwent psychometric behavioral assessments which did not indicate the need of work hardening program.

11. Range of motion and strength testing, 12/21/10: Reported left hip range of motion deficits with flexion 110 degrees, extension 20 degrees, abduction 45 degrees, adduction 25 degrees, internal rotation 30 degrees, external rotation 40 degrees. Lumbar spine had mild range of motion deficits of flexion 50 degrees, extension 15 degrees, side bending left and right 20 degrees. Muscle weakness noted to the left hip 4/5.

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

Based upon the available medical documentation reviewed and the ODG guidelines, the requested sessions of chronic pain management program is not reasonable or medically necessary. Documentation reports remote history of left hip replacement from an injury on xx/xx/xx. Recent functional assessment measurements have indicated mild range of motion deficits to the hip with mild strength loss which does not support significant disability. There is no report that the injured worker has plateaued in regards to measured functional gains from baseline level of formalized physical therapy in conjunction with conversion to a daily home exercise program emphasizing strengthening/endurance exercises. There are no indications that he has failed to achieve functional improvement from this baseline level of care. There are also no indications in the treatment notes that there is a full understanding of the injured worker that he is aware that successful treatment may change compensation and/or other secondary gains. The recommendation is to uphold the previous denial.

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

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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)