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Notice of Independent Review Decision

**December 27, 2010  
December 29, 2010 Amended**

**DATE OF REVIEW:** December 29, 2010

**IRO CASE #:**

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

Chronic Pain Management Program: 10 Sessions CPT: 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:**

The area of injury is the lumbar spine. The date of injury is xx/xx/xx. I am asked to uphold or overturn previous determination. I have not evaluated this patient; therefore, recommendations are based upon reasonable medical probability in the broadest possible sense.

I have an MRI of the lumbar spine without contrast from July 30, 2009, approximately seven weeks post injury. This was read by M.D. There appeared to be multilevel spondylosis in the lower lumbar spine. There was a mild broad-based disc space protrusion at L3-4. There was mild effacement of the anterior thecal sac and mild neural foraminal narrowing. The worst was at L4-5. There was a focal left posterior lateral disc protrusion and small annular tear. There was moderate left and mild right neural foraminal narrowing. There was mild degenerative facet change and ligamentum flavum hypertrophy with mild recess narrowing. There was an L5-S1 minimal disc bulge. There was an L2-3 mild broad-based disc bulge without neural impingement. There is no indication of any direct mechanical impingement upon the nerve elements.

There is a behavioral medicine consultation from August 4, 2009. A review of the documentation indicated the patient had worked two years for the company at the time of injury. The patient injured his low back while lifting a heavy drain cover. It is noted the patient was seen in the emergency room at received x-rays and pain medications. The patient was placed on light duty. The patient reinjured his back a month later. A CT scan of the lumbar spine without contrast on July 9, 2009, revealed degenerative spondylitic changes with predominant involvement of L3-4 and L4-5. There was probable moderate neural foraminal stenosis noted at L4-5 on the left. There were facet hypertrophic changes and annular bulging. This corroborates the previously reviewed MRI study.

Electrodiagnostic studies of the lower extremities revealed "electrophysiological manifestations found bilateral L5 and S1 radiculopathy secondary to prolonged bilateral peroneal F-waves and tibial H-reflexes." The reporting physician is M.D.

There is a consultation by D.O., from February 2, 2010, who corroborates an initial injury of xx/xx/xx. The patient was blowing some long pressure hoses. The patient injured his back by a mechanical shear when he twisted his back. He noted pain radiating to his legs. He was referred initially for an epidural steroid injection. The assessment of Dr., based upon his physical examination, was lumbar radiculopathy, myositis, and disc bulge with lumbar radiculopathy. There is no indication of any physical examination findings consistent with an L5-S1 radiculopathy. There is no indication of any type of reflex asymmetry or atrophy. The recommendation was for an epidural steroid injection.

I have a designated doctor exam report. This was performed by, M.D., on September 11, 2009. His assessment based upon his physical examination and review of records was multilevel degenerative disc disease. He hyphens this as an underlying impairment, acute lumbar strain, right lower extremity radiculopathy, and herniated nucleus pulposus at L4-5. The neurological assessment revealed symmetrical reflexes in the Achilles and patellar tendons

that were described as 1+. The patient was noted to complain of numbness in the lower extremities bilaterally. There is no corroboration of a dermatomal pattern of sensory loss on the impairment rating. Dr. did not feel that this patient was at maximum medical improvement. Epidural steroid injections were pending at that point.

An epidural steroid injection was performed by Dr. on February 25, 2010. This was well tolerated, without complications

The goals for treatment and recovery were set at an interdisciplinary chronic pain management program on September 16, 2010, by D.C. The physical performance evaluation was not completed due to functional limitations in the patient on the evaluation of September 16, 2010. The patient was only capable of functioning in the sedentary physical demand level. The recommendation was for a chronic pain management program to allow functional recovery. The physical performance evaluation revealed symmetrical lower extremity reflexes of 1+ in the patellar and Achilles tendons.

There is a history and physical by D.O. for chronic pain management program from September 22, 2010. He noted herniated discs at L2-3 through L5-S1 with right lumbar radiculopathy. It is noted the patient had one epidural steroid injection. Dr. felt the patient would be an excellent candidate for chronic pain management. The patient was continued on Darvocet and Elavil. The light duty work restrictions were continued. The recommendation was for chronic pain management modalities to include individual psychotherapy, medication management, vocational counseling, educational group therapy, and biofeedback.

In reviewing assessment documentation dated October 12, 2010, it is noted that after seven days of individual psychotherapy there were some mixed results. There was no change in sleep disturbance, forgetfulness, or irritability. A complete list of the patient's medications as of October 12, 2010, included Darvocet-N 100 q.i.d. p.r.n., Tramadol 50 mg p.r.n., Ibuprofen 800 mg q.i.d., Hydrochlorothiazide 25 mg daily, Flexeril 10 mg daily, and Elavil 50 mg at bedtime. There were mild increases in frustration and BDI-II (depression) and mild-to-moderate reductions in tension, anxiety, depression, and pain respectively. The greatest reduction was in pain and a 40% change was noted. Therefore, a comprehensive pain management program was recommended to facilitate additional recovery. Although previous pain management requests had documented no prior back injuries on designated doctor evaluation of September 11, 2009, the designated doctor notes that this patient had sustained a xxx work-related back complaint and had intermittent problems since that time.

There is a peer review by Ph.D., from October 25, 2010. When referencing the Official Disability Guidelines, Dr. felt that the chronic pain management program for ten days was not recommended as medically necessary. His rationale was that the patient's psychological symptoms were within appropriate limits. The Beck Depression Inventory was seen to be 9. It is felt that work conditioning or work hardening might be appropriate for this patient; however, chronic pain management program was not indicated as medically necessary.

I have no further documentation.

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

I am presented with a description of the services in dispute of chronic pain management program for ten sessions and asked for a review outcome. It is noted that the previous adverse determination should be upheld.

The rationale for this is that this patient appears to be experiencing multilevel spondylosis. This appears to be chronic and has been described in the medical records as degenerative. I cannot see anything that can be acutely and directly described in the medical records as related to an isolated lifting injury. Although radiculopathy has been reported on electrodiagnostic studies, this has been very poorly corroborated on serial physical examination findings. The patient's reflexes have been listed as symmetrical and without any evidence of radiculopathy. There has been no focal dermatomal pattern of sensory loss elucidated.

As far as summation is concerned, I have decided to overturn the previous decision with regards to chronic pain management. It is noted that the decisions are based solely on medical necessity and not on compensability. As such, the issue of causality is not in material to the decision.

In assessing chronic pain programs for the treatment of pain in the Official Disability Guidelines, this is recommended with stipulations, however. It is noted that simply being a patient in a chronic pain management program is a predictor of poor outcome. Comprehensive or multidisciplinary pain management is based upon the psychosocial model and, by admission, there is little scientific evidence to support the effectiveness of this model compared to other forms of therapy. However, it does state that there are criteria for the general use of multidisciplinary pain programs. They include an adequate and thorough evaluation; this has been accomplished. Previous methods of treating chronic pain have been unsuccessful; this is also quite apparent.

The patient has a significant loss of functional ability. The patient's last functional ability was described as sedentary, which did not meet his previous physical demand level of very heavy.

The patient is not a candidate for surgery. The nature of his anatomy would appear to be multifocal and degenerative. As such, there does not appear to be any single surgically amenable lesion which would likely result in material change.

The patient exhibits motivation to change and is willing to forego secondary gains. This is a more nebulous area; however, it is not disqualifying criteria as it clearly states in the Official Disability Guidelines a reasonable trial of two weeks is considered reasonable and necessary for the treatment of chronic pain as an ultimate mechanism for returning the patient to functional ability. However, this is predicated upon measurable and quantitative improvement in his overall functioning. A two-week course is considered reasonable and necessary, however, additional beyond the initial two-week course has to be predicated

upon measurable and appropriate amounts of functional improvement; without this, there is no utility for continued care.

Based upon the patient's rather mixed response to individual psychotherapy, the psychosocial model might not be effective in this case. However, that is not a disqualifying attribute for chronic pain management.

Once again, the chronic pain management program would be useful in an attempt to return him to his previous functional ability. However, this has to be predicated upon measurable quantitative improvement of a two-week course as an initial trial. Therefore, the patient is authorized with stipulation that this be reviewed in a two-week period to determine the efficacy of additional care.

**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)