

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 12/23/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Chronic Pain Management 5xWk x 2Wks (80 hours) 97799

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

Texas Licensed Chiropractor

REVIEW OUTCOME

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

Denial Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx when she hit her right elbow on a metal bar.

A Functional Capacity Evaluation (FCE) performed 03/09/09 stated the employee's occupation as a required a medium physical demand level. The employee was currently performing at a light physical demand level. The employee was recommended for physical therapy.

The employee saw Dr. on 03/16/09. Prior treatment included physical therapy and an injection to the lateral condyle of the right distal humerus. The physical examination revealed normal range of motion of the right elbow. There was no muscle atrophy noted. There was noted marked tenderness over the lateral epicondyle. There was pain with supination and pronation. There was soreness in the forearm over the right brachial radialis muscle. The employee was referred for steroid injections to the lateral epicondyle.

The employee saw Dr. on 04/16/09. The employee complained of persistent lateral epicondyle pain rating 6 to 7 out of 10. Physical examination revealed tenderness directly over the lateral epicondyle. The pain was reproduced with resisted wrist extension. There was radiation of pain from the lateral epicondyle into the proximal forearm. There was no apparent tenderness over the radial tunnel noted. There was significant pain over the ulnotrochlear articulation as primarily over the lateral epicondyle. The employee was assessed with right lateral epicondylitis. The employee was given a steroid injection to the lateral epicondyle.

The employee saw Dr. on 05/07/09. The employee reported fairly good relief from the injection. The employee rated the pain at 4 out of 10. Physical examination revealed mild tenderness at the lateral epicondyle. There was some reproduction of mild pain with resisted wrist extension. The employee was advised to follow-up with exercises and stretches.

The employee saw Dr. on 05/28/09 with complaints of worsening lateral epicondylitis pain. The employee rated the pain at 5 out of 10. Current medications included Vicodin. Physical examination revealed tenderness directly over the lateral epicondyle. There was pain with resisted wrist extension. There was no significant ulnar trochlear or radial capitellar tenderness. There was no significant tenderness to palpation over the radial tunnel. The employee was assessed with right lateral epicondylitis.

Electrodiagnostic studies performed 11/24/09 were abnormal with findings consistent with mild right carpal tunnel syndrome. The employee was given a steroid injection to the right lateral epicondyle. A treatment progress report dated 02/10/10 revealed a BDI score of 27, indicating a moderate to severe level of depression. This was a 1 point increase. The BAI score was 12, indicating a mild level of anxiety. This remained consistent with the employee's previous score. The employee was recommended for individual psychotherapy sessions.

The employee saw Dr. on 03/17/10 for medication management. The employee was prescribed Cymbalta and Xanax.

The employee saw Dr. on 07/30/10. The employee rated her current pain at 0 out of 10, but stated it averages around 1 to 2 out of 10. The pain worsened with pushing, pulling, and pronation. Physical examination revealed right elbow strength of 4+/5 secondary to pain. There was overall improved stability, but the employee lacked endurance in the right upper extremity. Range of motion of the right elbow was 120 degrees of flexion and -1 degree of extension. Palpation of the right brachial radialis reveals trigger points. The employee was advised to follow-up in two weeks.

The employee saw Dr. on 08/13/10. The note stated the employee was status post right lateral epicondylectomy. The operative report was not submitted for review. The employee rated her pain at 2 to 3.5 out of 10. The employee reported difficulties with pushing, pulling, and most pronation. Repetitive use of the upper extremity caused irritation. Physical examination revealed 4+/5 strength secondary to pain. There was some chronic myofascial irritation noted in the right brachial radialis. Range of motion showed 121 degrees of flexion and 1 degree of extension. The right elbow was orthopedically stable. There was some giveaway pain, particularly with pronation at 50 degrees. The employee was assessed with right lateral epicondylectomy. The

employee was recommended for chronic pain management.

A Functional Capacity Evaluation performed 09/20/10 stated the employee's occupation as a required a light physical demand level and the employee's current physical demand level was listed as medium. Later under "Recommendations", the reports stated the employee was currently functioning in the light category of work, and she was recommended for a chronic pain management program.

The request for chronic pain management was denied by utilization review on 10/27/10 due to the employee's reported physical demand level of medium with an occupational requirement of light. In addition, the employee was currently being recommended for two hours of additional psychological testing. **Official Disability Guidelines** states that all diagnostic studies and treatments should be completed prior the employee's entering a chronic pain management program.

A treatment progress report dated 11/12/10 stated the employee had attended twelve sessions of individual psychotherapy. The employee's BDI score was 20, indicating moderate to severe depression. This represented a 7 points drop in depressive symptoms. The employee's BAI score was 10, indicating mild anxiety. This represented a 2 point drop in anxiety symptoms. The note stated the employee had exhausted all primary and secondary levels of care. With her present physical condition, the employee was in need of tertiary care, specifically a multidisciplinary chronic pain management program.

The request for chronic pain management was denied by utilization review on 11/29/10 due to the physical demand level being commensurate with return to work. An appeal letter argued that the physical demand level was reported in error. BHI-2 provided clear evidence of poor perseverance. This was a poor predictor of success. This score suggested the employee was a poor candidate for daily care with high levels of activity expected.

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

The clinical documentation provided for review addresses the previous denials that were based solely on the provided FCE for the employee. The appeal letter indicates that the employee was actually at a light physical demand level. The remainder of the clinical documentation does indicate that the employee has attempted all reasonably lower levels of care and the BHI-2 evaluation does demonstrate findings of continued disability secondary to chronic pain. The employee would reasonably require an initial 10 sessions of chronic pain management.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Online Version, Pain Chapter