INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 01/11/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Chronic Pain Management 5 x wk x 2 wks 97799

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 04/07/10 - Clinical Note - M.D.
2. 05/19/10 - Clinical Note - D.C.
3. 06/10/10 - Clinical Note - M.D.
4. 08/03/10 - MRI Lumbar Spine
5. 08/12/10 - Electrodiagnostic Evidence
6. 09/16/10 - Pre-Surgical Consultation and Behavioral Assessment
7. 09/22/10 - Clinical Note - M.D.
8. 09/30/10 - Correspondence - M.D.
9. 09/30/10 - Utilization Review
10. 10/06/10 - Clinical Note - M.D.
11. 10/23/10 - Peer Review
12. 10/27/10 - Clinical Note - M.D.
13. 11/01/10 - Clinical Note - M.D.
14. 11/17/10 - Utilization Review
15. 12/03/10 - Utilization Review

16. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury when she lifted some boxes and felt pain to the low back.

The clinical notes begin with an evaluation by Dr.. The note stated the employee was status post an epidural steroid injection that provided minimal relief. The employee complained of low back pain with a pinching sensation over the right side. The employee denied numbness, tingling, or pain in the legs. Physical examination indicated some exaggeration of grimacing with movements. There was tenderness in the back area. Deep tendon reflexes were 1+. Sensation to light touch was equal. Straight leg raise produced pain on the right at 60 degrees. The employee was recommended for a home exercise program.

The employee saw Dr. on 05/19/10. The employee reported low back pain with a burning pain into the right lower extremity. Physical examination revealed normal strength of the upper and lower extremities. There was positive nerve root testing in the right lower back. Deep tendon reflexes were globally suppressed bilaterally. There was decreased sensation down into the right S1 dermatomes. Motor strength was 5/5. The employee was assessed with lumbar disc herniation and lumbar radiculopathy. The employee was placed on light duty and was referred for surgical evaluation.

The employee saw Dr. on 06/10/10 with complaints of low back pain and lower extremity pain. The employee denied bowel or bladder dysfunction. The pain worsened with walking and prolonged sitting. Physical examination revealed mild soft tissue paraspinal pain with palpation. Lumbar forward flexion was to 25 degrees with pain. Straight leg raise was positive on the right at 50 degrees. The employee was able to toe and heel walk with pain. The employee was recommended for an MRI of the lumbar spine and electrodiagnostic studies.

An MRI of the lumbar spine performed 08/03/10 demonstrated mild facet arthropathy at L2-L3. There was no central canal or foraminal stenosis. At L3-L4, there was a mild diffuse disc bulge with a focal superimposed left paracentral/foraminal disc protrusion. There was mild bilateral facet arthropathy. There was mild bilateral neural foraminal narrowing without mass effect on the exiting nerve roots. There was no canal stenosis. At L4-L5, there was a mild diffuse disc bulge with focal superimposed central disc protrusion measuring up to 4 mm. There was mild bilateral facet arthropathy and ligamentum flavum hypertrophy. There was mild foraminal narrowing without mass effect on the exiting nerve roots. At L5-S1, there was Grade 1 anterolisthesis of L5 on S1. There was central disc protrusion measuring up to 5 mm. There was severe bilateral facet arthropathy. A right facet effusion was noted. There was narrowing of the lateral recesses and possible encroachment on the traversing nerve roots. There

was moderate-severe bilateral neural foraminal narrowing with impingement on exiting L5 nerve roots.

Electrodiagnostic studies performed 08/12/10 revealed evidence most consistent with an active/chronic radicular process involving the right S1 nerve root.

The employee was seen for a presurgical consultation and behavioral assessment on 09/16/10. The employee denied any suicidal or homicidal ideation. The employee complained of pain in the right low back that radiated down the right lower extremity. The employee rated her current pain at 4 to 5 out of 10 on the visual analog scale. The employee's BDI score was 14, indicating mild to moderate depression. The employee's BAI score was 6, indicating mild depression. The employee was felt to be an appropriate candidate for the proposed surgical intervention.

The employee saw Dr. on 09/22/10 with complaints of low back pain. The employee reported increased pain with prolonged sitting or standing. The employee ambulated with an antalgic gait due to right leg pain. The employee denied bowel or bladder dysfunction. The employee's Oswestry score was 58%. The employee rated her pain at 6 out of 10 on the visual analog scale. Current medications included Lisinopril, Tizanidine, and Darvocet. Physical examination revealed restricted lumbar flexion and extension. There was mild to moderate right-sided buttock tenderness. Radiographs of the lumbar spine demonstrated a Grade 1-2 spondylolisthesis at L5-S1. There was 4 mm of translation from extension to flexion. The employee was assessed with disc protrusion of L4-L5 and L5-S1, lumbar radiculopathy of L5-S1, and spondylolisthesis of L5-S1. The employee was recommended for transforaminal lumbar interbody fusion at L5-S1 with instrumentation and interbody fusion.

The employee saw Dr. on 10/06/10. Physical examination revealed the employee was able to ambulate without assistive devices and was independent with positional changes. There was no dysarthria, dysphonia, and aphasia. Reflexes were 2+ at the patella and 1+ at the Achilles. The employee was assessed with lumbar intervertebral disc and lumbar radiculopathy. The employee was prescribed Zanaflex 4 mg and Vicodin 5/500 mg.

The employee saw Dr. on 10/27/10 with complaints of right sided low back pain that extended into the right buttocks. The employee reported intermittent paresthesias. The employee had failed conservative treatment, to include physical therapy and injections. The note stated Vicodin was not effective at controlling her pain. Physical examination revealed no dysarthria, dysphonia, and aphasia. Reflexes were 2+ at the patella and 1+ at the Achilles. The employee was assessed with lumbar intervertebral disc and lumbar radiculopathy. The employee was prescribed Zanaflex 4 mg, Vicodin 5/500 mg, and Ultram ER 300 mg.

The employee saw Dr. on 11/01/10. The employee complained of low back pain and muscular spasms. The pain worsened with prolonged sitting, standing, and walking. The employee also reported mood swings and sleep disturbance. Current medications included Hydrocodone and Zanaflex. Physical examination revealed mild to moderate tenderness to palpation of the lumbosacral spine. There was slight tenseness of the paravertebral muscles. The employee was able to walk on her toes and heels with moderate difficulty. Straight leg raise was negative bilaterally. Patellar reflexes were present. Sensation was grossly intact. Muscle strength was 5/5 in all groups tested. The employee was assessed with herniated nucleus pulposus of the lumbosacral spine by history. The employee was prescribed Cymbalta, Zanaflex, and Hydrocodone. The employee was recommended for a Functional Capacity Evaluation (FCE) and a mental health evaluation.

The request for chronic pain management 5 x wk x 2 wks was denied by utilization review on 11/17/10. The reviewer's comments have been cut off, but it appears the documentation was unclear as to whether the employee had exhausted all other avenues.

The request for chronic pain management 5 x wk x 2 wks was denied by utilization review on 12/03/10 due to lack of objective evidence that previous methods of treating the employee's chronic pain had been unsuccessful, and that there was an absence of other options likely to result in significant clinical improvement. It was not clear if the employee was not a candidate for further diagnostic injections or other invasive or surgical procedures. Functional objective responses through visual analog pain scale, procedural notes, and physical therapy progress notes were not provided. Any official reports of recent diagnostic imaging examination to rule out other pain generators were not provided for review. Treatment goals were not specific and time-limited. There was no clinical documentation from the requesting physician regarding a recent physical examination addressing in detail the necessity of the requested services.

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

There is a lack of documentation provided for review demonstrating that the employee has failed lower levels of conservative care. The clinical records provided states the employee failed to improve from injections or physical therapy, but procedural notes or physical therapy progress notes were not submitted for review. Current evidence-based guidelines suggest a thorough multidisciplinary evaluation to include an independent psychological evaluation, which was not submitted for review.

Given the lack of documentation regarding the employee's multidisciplinary evaluation and the employee's lower levels of care, the requested chronic pain management program is not recommended as medically necessary.

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.