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Notice of Independent Review Decision

DATE OF REVIEW: 06/02/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Referral for treatment, medication, and pain management related to the lumbar spine

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Certificate for Added Qualifications in Pain 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Referral for treatment, medication, and pain management related to the lumbar spine - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A CT scan of the lumbar spine interpreted by M.D. dated 03/31/06
Physical therapy with an unknown provider (no name or signature was available) dated 05/01/06, 05/03/06, 05/05/06, 05/08/06, 05/10/06, 05/12/06, 05/26/06, 05/30/06, 05/31/06, 06/02/06, 06/12/06, and 06/19/06

Evaluations with D.C. dated 05/12/06, 06/20/06, 03/28/07, 04/12/07, 10/28/10, 11/09/10, and 03/18/11

A patient information form dated 03/15/07

A medical documentation review from D.O. dated 01/21/11

Authorization request letters from Dr. dated 05/04/11 and 05/13/11

A letter of non-authorization, according to the Official Disability Guidelines (ODG), from, M.D. dated 05/10/11

A letter of non-authorization, according to the ODG, from M.D. dated 05/23/11

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

According to records provided by Dr. this patient aggravated a low back injury that originally occurred in xxxx, causing a new TWCC file to be opened on the aggravation date of xx/xx/xx. The chiropractor noted that the patient had significant co-morbidities, including morbid obesity, prior disc surgery, disc degeneration, deconditioning, left leg below-knee amputation, and peripheral neuropathy of the right leg. The CT scan report dated 03/31/06 documented disc space narrowing and circumferential bone spur formation, indicating chronic disc degeneration and mild L5-S1 canal stenosis. Moderate bilateral foraminal stenosis was noted due to bone spurs and facet arthrosis. Similar findings were also seen at L4-L5. Mild annular bulging and facet arthrosis was also noted at L3-L4 causing moderate canal stenosis with similar findings at L2-L3. Dr. saw the patient for treatment on 05/01/06 and 05/03/06. On 05/12/06, Dr. followed-up with the patient, noting his complaint of left low back pain radiating into the left hip and leg, despite the fact that the patient had a left below-knee amputation. He noted that the patient had received six treatments from him over the previous two weeks with a "significant" reduction in "outcome assessment." Dr. then continued treatment on 06/12/06 and 06/19/06, noting that the patient had "no low back pain" on 06/12/06, but continued to have leg pain. On 03/28/07, Dr. followed-up with the patient. After the patient had completed treatment in June 2006, his pain level was said to be approximately 3/10. His pain level on 03/28/07 was 9/10. After treatment in June 2006, the patient's Oswestry Low Back Pain and Disability level was said to be 48% and it was now 84%. The patient's Roland Morris Low Back Pain and Intensity score after treatment in June 2006 was 12/24 and it was currently 21/24. The patient was noted to be six feet four inches tall and weighed 360 pounds. He had marked pain and tenderness of bilateral thoracolumbar muscles and bilateral iliolumbar muscles. Dr. recommended passive modalities and one month at three times a week of physical therapy. On 11/09/10, Dr. reevaluated the patient, noting his intense low back pain ranging from 5-10/10 and he reviewed the medications as prescribed by Dr.. Dr. noted the patient's left leg had been amputated in 1997 or

1998 and that his sedentary lifestyle had “caused him to become morbidly obese.” The patient’s pain level was said to be 8/10. Physical examination documented bilateral thoracolumbar hypotonicity and tenderness as well as moderate pain and tenderness bilaterally over the iliolumbar muscles. Dr. noted, “There are obviously several complaints of morbidity as mentioned above. These factors complicate and predispose Mr. to increased pain.” On 03/15/11, Dr. followed-up with the patient, again documenting no physical examination, no pain level, and no specific complaint other than “chronic low back pain.” He again recommended “referral for pain management.” On 05/10/11, a physician adviser recommended non-authorization for the request for treatment, medication, and pain management related to the lumbar spine. On 05/23/11, a different physician reviewer concurred with the recommendation for non-authorization. He noted no new medical information had been provided with the request for reconsideration and his opinion that “further treatment is not necessary including further testing or medications.”

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

As each of the two physician advisers pointed out, there is, quite simply, absolutely no physical examination evidence whatsoever of radiculopathy, neuropathy, or evidence of objective findings to support the patient’s ongoing subjective low back pain complaints. Additionally, there is no documentation of this patient obtaining any significant benefit from the previous Vicodin and Soma prescriptions provided by Dr.. In fact, during the time he was taking these medications, it appears that the patient’s pain complaints and pain level were no less and no better than at any other time during the period of documentation provided for my review. I agree with Dr. and the two physician advisers that there is no medical reason or necessity for any further treatment of this patient’s subjective low back pain complaints as related to the work injury of xxxx. Moreover, there is no support in the ODG Treatment Guidelines for the use of Soma, a muscle relaxant, for treating chronic pain. Soma, in fact, metabolizes to meprobamate, which is a highly addictive substance. Therefore, the use of Soma was not medically reasonable or necessary, according to the ODG and exposes the patient to significant risk.

In summary, the requested referral for treatment, medications, and pain management related to the lumbar spine is not reasonable or necessary. Therefore, the recommendations for non-authorization of this request by the two previous physician advisers are both upheld 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 AND KNOWLEDGE BASE**

- 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)