

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 03/02/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic Pain Function Restoration 10 sessions

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

Texas Licensed Psychologist

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. 10/07/03 - MRI Cervical Spine
2. 10/07/03 - MRI Left Shoulder
3. 10/21/03 - Radiographs Lumbar Spine
4. 10/21/03 - MRI Lumbar Spine
5. 10/24/03 - Electrodiagnostic Studies
6. 11/12/03 - Radiographs Lumbar Spine
7. 11/12/03 - Radiographs Cervical Spine
8. 11/12/03 - Radiographs Left Shoulder
9. 02/13/04 - Operative Report
10. 10/15/04 - Electrodiagnostic Studies
11. 05/10/05 - Electrodiagnostic Studies
12. 05/12/05 - MRI Lumbar

- 13.07/07/05 - Post-Myelogram Lumbar CT
- 14.08/12/05 - Operative Report
- 15.12/13/05 - Work Task Analysis Report
- 16.11/22/10 - Clinical Note - MD
- 17.12/17/10 - Clinical Note - Unspecified Provider
- 18.12/22/10 - Utilization Review
- 19.01/13/11 - Appeal Letter
- 20.01/19/11 - Utilization Review
- 21. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he struck his left shoulder on a tray loaded on a forklift, knocking him backwards onto his head, neck, and low back.

An MRI of the cervical spine performed 10/07/03 demonstrated a 2 mm posterior protrusion at C3-C4 and C4-C5 that effaced the anterior subarachnoid space. There was no central canal stenosis or marked foraminal narrowing. At C5-C6, there was a 3 mm posterior protrusion that effaced the anterior subarachnoid space and abuts the cord. There was no central canal stenosis or marked foraminal narrowing.

An MRI of the left shoulder performed 10/07/03 demonstrated marked anterior cuff tendonitis. The cuff was swollen and edematous. There was no visible tear, atrophy, or retraction. There was mild distention of the subacromial/subdeltoid bursa. A Type II/III acromion was present. There was moderate acromioclavicular joint arthritis present.

Radiographs of the lumbar spine performed 10/21/03 revealed no acute compression fracture or listhesis. There was moderate anteroposterior hypertrophic spondylosis with sizable anterior osteophytosis noted with slight reduction of the fourth disc height. Facet arthropathies were noted throughout the levels.

An MRI of the lumbar spine performed 10/21/03 demonstrated a diffuse posterior protruded disc at L4-L5, more left intra-foraminal herniated disc at L4-L5.

Electrodiagnostic studies performed 10/24/03 revealed a mild left-sided C5-C6 radiculopathy. There was no myopathy, neuropathy, or brachial plexopathy.

Radiographs of the lumbar spine performed 11/12/03 revealed a large osteophyte seen posteriorly on the inferior endplate of L5. There was another osteophyte seen on the superior end plate anteriorly.

Radiographs of the cervical spine performed 11/12/03 revealed preservation of the normal lordosis. The disc space height was well-preserved. There was no spondylolisthesis or spondylolysis.

Radiographs of the left shoulder performed 11/12/03 demonstrated some osteophytic projection under the acromion.

The employee underwent left shoulder debridement of partial thickness rotator cuff tear, debridement of Grade I SLAP lesion of the left shoulder, and subacromial decompression of the left shoulder on 02/13/04.

Electrodiagnostic studies performed 10/15/04 revealed subacute right L5 radiculopathy.

Electrodiagnostic studies performed 05/10/05 were negative for lumbar radiculopathy, peripheral neuropathy, or motor neuron disease.

An MRI of the lumbar spine performed 05/12/05 demonstrated mild narrowing and minimal loss in signal of this disc with a very large, at least 4 mm, right posterolateral disc herniation obliterating the right lateral recess and extending into the inferior aspect of the intervertebral foramen. The posterior central margin of this disc showed a bulge, but as one approaches the left intervertebral foramina, there was at least a 2 mm disc herniation within the inferior aspect. At L5-S1, there was normal signal with a posterior central disc bulge.

Postmyelogram lumbar CT performed 07/07/05 confirmed a 4 mm right posterolateral disc herniation and a 2 mm left posterolateral disc herniation at L4-L5.

The employee underwent decompression at L4 and L5 with partial laminectomy, exploration of L4-L5, posterolateral L4-L5 fusion, and instrumentation with pedicle screws at L4 and L5 on 08/12/05.

A Work Task Analysis Report dated 12/13/05 stated the employee's occupation required a heavy physical demand level.

The employee saw Dr. on 11/22/10. The employee complained of left shoulder pain shooting down the left arm. The employee rated the pain at 7 out of 10. Physical examination revealed limited range of motion of the left shoulder with stiffness. There was numbness and tingling down the left arm. There was

decreased grip strength of the left upper extremity. The employee was assessed with left shoulder pain, left shoulder radiculitis, and lumbar radiculitis. The employee was prescribed Vicodin and Skelaxin. The employee was recommended for a Functional Restoration program.

The employee was seen for evaluation on 12/17/10. The employee complained of chronic pain in the left shoulder that radiated into the left arm. He also reported numbness and sleep disturbance due to pain, anxiety, and depression. The employee rated his pain at 7 to 8 out of 10. Prior treatment included cervical epidural steroid injections, cervical facet-medial branch nerve block, lumbar epidural steroid injections, and manipulation under anesthesia of the left shoulder.

The employee underwent extensive physical therapy from 2003 through 2006, chronic pain management from April through May 2006, and work hardening from February through April 2007. Current medications included Vicodin ES and Skelaxin. The employee's BAI score was 26, indicating severe anxiety. The employee's BDI score is 24, indicating moderate depression. BBHI-2 testing reveals very low defensiveness, high somatic complaints, moderately high pain complaints, high functional complaints, high depression, and very high anxiety. The employee's GAF score is 60. The employee was assessed with pain disorder associated with a general medical condition and psychological factors and adjustment disorder with depressed mood. The employee was recommended for ten sessions of a functional restorative program.

The request for chronic pain function restoration was denied by utilization on 12/22/10 as the psychological evaluation performed 12/17/10 was inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments were inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain the symptoms, and to help design and predict response to treatment. There was no thorough behavioral psychological examination to provide a reasonable manifest explanation for the etiology and maintenance of employee's clinical problems. The reviewer was unable to establish a basis that this treatment was both reasonable and necessary at this time.

The request for chronic pain function restoration was denied by utilization review on 01/19/11 as the employee had already completed thirty sessions of a chronic pain management program and a multidisciplinary work hardening program. There was no assessment of the factors that may have contributed to the employee's inability to benefit from a previous chronic pain management program and a multidisciplinary work hardening program. After completion of these multidisciplinary interventions, there was no functional improvement

reported and the employee did not return to work. This was a negative predictor and presents a poor prognosis for the requested treatment.

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

The requested chronic pain function restoration program is not recommended as medically necessary. The employee has completed two tertiary rehabilitation programs in 2006 and 2007 that failed to return the employee to work. Current evidence-based guidelines do not recommend repeat tertiary rehabilitation programs when there has been poor outcomes from prior programs. There is also a large gap in clinical documentation after the most recent rehabilitation program that indicates what care was provided to the employee or the employee's documented response to that treatment. Given the failure of prior functional restoration programs, the persistent disabled status of the employee, it is unlikely that the employee will have a good outcome from a third functional restoration program.

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