

# P&S Network, Inc.

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## **MEDICAL RECORD REVIEW:**

**DATE OF REVIEW:** 03/01/2011

**IRO CASE #:**

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

This case was reviewed by a Pain Management doctor (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

1 Office visit for medications between 1/19/2011 and 3/20/2011

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

According to the medical records and the patient is a female employee who sustained an industrial injury when she tripped over a pallet when coming through the doorway causing her to fall backwards on her left side on xx/xx/xx. She underwent a left rotator cuff repair in June 2003 and left shoulder debridement due to infection of wound in July 2003 and left shoulder decompression and distal clavicle resection in April 2004.

Narrative report dated January 2, 2010 described the incident of injury, a fall, with resulting neck pain with radiation to the hand with numbness and tingling and lower back pain radiating to the left leg. She had a MRI of the left hand and shoulder. However, there was no workup for the neck and lower back. She eventually required arthroscopic surgery to the left shoulder with complications of a wound infection which required debridement. Her left wrist was also treated. A cervical MRI was significant for disc herniation at C5-6. Lumbar MRI was significant for severe bilateral L5 neural foraminal narrowing and moderate bilateral L4 neural foraminal narrowing with posterior lateral disc bulge at those levels. An EMG/NCV was suggestive of cervical radiculopathy; lumbar EMG was reportedly significant for L5-S1 radiculopathy. She eventually underwent cervical and lumbar ESI with no lasting benefit. A neurosurgeon determined she was not a surgical candidate. She also underwent a pain management program. She complains of 7/10 pain at the left shoulder, neck and lower back. She also has left wrist and right knee complaints. Medications provide only 50% pain relief. Her weight is 219 pounds. Spurling's sign is negative. Shoulder impingement sign is positive. Lumbar ROM is slightly restricted. She has a normal upper and lower extremity neurological exam. Straight leg raise is negative. She is using hydrocodone every 8 hours,

tizanidine, and Lexapro. She will continue with HEP and return every 3 months.

The patient was reevaluated on February 5, 2010 for neck, shoulder and lower back pain of 6/10 severity. She has 50% relief with her medications. Blood pressure is 152/87. Her weight is 228 pounds. Left shoulder flexion is 100 degrees and abduction 80 degrees. Impingement signs are positive. Straight leg raise is negative. Left plantar flexion strength is 4/5. Medications were refilled including hydrocodone, tizanidine and Lexapro. She will return in three months.

The patient was seen in pain management on April 29, 2010 for evaluation. She has been treated extensively since xxxx. She reports generalized pain of 7-10/10. She has become progressively despondent, depressed and fatigued. Her responses indicate moderate to severe reactive depression and anxiety as it relates to chronic pain. She underwent injection treatment in the past with no sustained relief and presents for a second, fourth or fifth opinion. She states the weak narcotic analgesic (hydrocodone), muscle relaxant and SSRI are not beneficial. She notes no sustained improvement with her left shoulder surgeries. She smokes half pack daily. She is 5' 2" and 203 pounds. Left straight leg raise is positive at 70 degrees. No motor or sensory deficits are noted. Diagnosis is chronic pain syndrome associated with cervical disc protrusion and bilateral cervical and lumbar radiculopathy. She has generalized myofascial pain syndrome in a chronic pain state and moderate reactive depression and anxiety in a chronic pain state. She will have medication management and then injection therapy will be provided in conjunction with PT and rehab efforts. Wellbutrin will be initiated and Lexapro discontinued. She will increase her Zanaflex to 8 mg qhs.

The patient returned on May 13, 2010. She has clear evidence of lumbar radiculopathy as evidence by a positive straight leg raise on the left, decreased lumbosacral flexion and moderate interspinous back tenderness. She is not being given medications in a timely manner. She will be given samples of Cymbalta 30 mg to be increased to 60 mg q. am. Wellbutrin has been recommended and ESI will be considered in the near future.

The patient was seen again on June 4, 2010. Wellbutrin is recommended for mood and also it should help her to quit smoking. ESI has been denied. She has an EMG consistent with radiculopathy and positive straight leg raise on examination. A second request is made for injection.

The patient underwent a Required Medical Examination on August 3, 2010. She was previous evaluated on October 31, 2003. At that time RME opinions stated no additional diagnostic testing, treatment, or therapy was reasonable and necessary other than pharmacological pain management. She continued to receive chiropractic care throughout 2003. The patient fell almost x years prior. She had a prior left shoulder injury and underwent acromioplasty in June 2000 but was never any better. She had been doing light duty since 2000. She has continuing decreased left shoulder ROM since 2000. She came under medical/chiropractic care. She was found to have a left wrist fracture and was casted. She had a prior surgery in March 2001 for left rotator cuff repair and impingement. She was still attending work conditioning and physical medicine at the time of the current injury. The medical notes indicate extensive physical therapy and a Designated Doctor deemed her at MMI as of July 13, 2002 with 12% WPI. He concluded that the patient's lower back, neck and hip injuries were minor and should not require any interventional treatment. He felt the left wrist/forearm problems were minimal and would continue to improve with time. She had prior CTS and her present symptoms were consistent with that condition. She was awarded zero impairment for the neck and lower back and 5% for impaired left hip motion and 8% for the left shoulder and 10% for the left wrist.

According to the RME, she underwent a psychological evaluation on September 3, 2002 with impression of acute pain disorder with psychological factors and a mood disorder resulting from physical injury. She had a left shoulder surgery on September 3, 2002. Some post-op infection was suspected and she underwent a second surgery on July 8, 2003. 22 staples were removed, the wounds were cleaned and cultures taken. She was placed on antibiotics. She subsequently underwent two MUAs of the left shoulder with no reported benefit. She underwent a left wrist MRI in January 2004, which revealed widening of the scapholunate joint space consistent with scapholunate dissociation. She continued to complain and was not further improved with chiropractic or PT. Notes from March 2004 indicate she was using Ambien and Vicodin and was in PT once a week and was doing the same. Notes from March 2004 indicated her orthopedic provider felt she should undergo left shoulder surgery again with arthroscopy, SAD, and distal clavicle resection. She underwent a third left shoulder surgery on April 28, 2004. She was deemed MMI by a Designated Doctor as of April 8, 2004 with 14% impairment. She was approved for further treatment to her neck and low back

She continued to receive physical therapy twice per week. As of the prior RME evaluation on July 2004 she was being treated twice weekly with no improvement noted. RME opinions noted she is not likely to be further improved and further chiropractic and PT was not reasonable or medically indicated. She could continue the prescription analgesic medication as needed but there was not evidence for continued use of Ambien. In August 2004 she came under management of her current provider.

Chiropractic

care was re-initiated in October 2004. She consistently rated her pain as 8/10 despite all the treatments. She continued to receive PT three times weekly with no change in her condition. At RME evaluation of November 22, 2005 she indicated multibody part pains that were present every day, all day. She rated her pain as 7/10, sometimes 10/10. It was noted that she remained unchanged despite all treatments. Over the counter analgesic medication and home physiotherapy was recommended. She has continued to treat extensively, again without any significant improvement. An EMG/NCV was done in August 2006 by the current provider and he interpreted it to show moderate right and left S1 radiculopathy. However, this was based on increased insertional

activity in the L4-5 paraspinous muscles and the right S1 paraspinous muscles with no findings in any of the distal musculature. This does not meet the AANEM criteria for the diagnosis of radiculopathy and should be considered an invalid conclusion.

Per the RME the patient began pain management in February 2008 with report of 8/10 pain and 50% relief with medication. The medications were reported as Lexapro 10 mg once a day, Tizanidine 2 mg 1-2 every night and Hydrocodone 5/500 one every 8 hours. The patient admitted that she was not using all this medication and it was piling up. At RME evaluation of July 7, 2008 she noted treatment of medications only. She noted her symptoms were unchanged and her pain was constant and severe. RME opinion was for management with medication of hydrocodone only and semi-annual follow-ups. There was no evidence of active ongoing depression and Lexapro should have been weaned. She was chronic and stable. She has persistent symptomatic pain complaints without objective findings. She should be able to manage her symptoms with OTC medication and there was no indication for any additional injections or specific therapy. She has since seen the new provider who reports she has 50% relief with medications, which is questioned as she should then have 5/10 pain. She takes Hydrocodone twice a day but medications

are refilled for use every 8 hours. On March 6, 2009 the provider indicates use of Hydrocodone and Lexapro but does not mention the tizanidine, which the patient states he provides for daily use. On June 5, 2009 a thorough examination was not reported. Per RME evaluation of August 4, 2009 the patient reported her overall response to treatment was unchanged. Her pain complaints did not match the reported pain levels. She noted new pain in her knees with no report of any new injury. She complained of weakness of all her body parts. Examination noted giving way weakness of the upper extremities and a normal neurological examination. There was no sciatic pain with straight leg raising. Her lower extremity neurological exam was normal. Several Waddell signs were positive. It was RME opinion that medical care should have ceased in 2005. There was no evidence of any significant clinical response to any of the medications previously used. Hydrocodone should have been weaned. Tizanidine was not supported by ODG and should have been weaned. There was no evidence for any ongoing muscle spasm. With regard to Lexapro the patient has no evidence of depression as a direct natural result of her primary injury as it is noted by multiple appeals panels decisions that psychiatric injuries are only compensable if it is a direct natural result of a primary injury of itself and is of a permanent nature. Any secondary consequences or reactive difficulties following an injury, including reactions to chronic pain, financial issues and frustration with insurance carriers in the process of acquiring benefits are judged by appeals panels to be disease of ordinary life and therefore not compensable.

An additional follow up note dated February 5, 2011 has been submitted. The findings are compared with a report from her other provider dated April 29, 2010. RME conclusions state, the medical care rendered has not been reasonable or necessary and her medical care should have ceased after November 22, 2005. No continued chiropractic treatment, PT, work hardening, pain management, injections or diagnostic testing would be considered reasonably required. No durable medical equipment is indicated. There is no indication for any surgery with regard to the original injury. The medications are not reasonable as noted above. Hydrocodone should be weaned immediately to one tablet a day for two weeks then one tablet every other day for two weeks and then cessation. Tizanidine can be stopped without weaning. Lexapro can be weaned over a 4-6 weeks period of time as described. She had been changed to Cymbalta but it remains unknown of she has actually started the medication and at what current dose. No epidural should have ever been certified. She does not have a positive straight leg raising. The reviewed reports do not document any radiculopathy other than report of straight leg raising. As noted the prior EMG/NCV study cannot be considered valid as it does not meet the AANEM criteria for the diagnosis of radiculopathy and over an extensive period of time she has not manifested any objective clinical findings consistent with radiculopathy.

On December 13, 2010 the patient underwent a lumbar ESI at L5-S1.

The patient was reevaluated in pain management on August 30, 2010. She responded favorably to lumbar epidural blocks assessing more than 70% improvement of her back, left buttock and left leg pain complaints. She clearly had lumbar radiculopathy. Contrary to the reviewer's opinions the patient has an inflammatory lesion consistent with a radiculopathy. Radiculopathy was supported by positive EMG studies as well as clinically with findings of a positive straight leg raise, moderate sciatic notch tenderness and a decreased pinprick sensation. She had responded to the treatment which further confirms the diagnosis. A second block is recommended. She noted her medications are not being approved. Guidelines support four injections annually. Medications were refilled including her Wellbutrin which has helped stabilize her mood and Zanaflex which is helping her paravertebral spasm and tightness which she again demonstrated today (a physical examination is not otherwise reported). She is taking an occasional Vicodin, no more than 2-3 daily. Her smoking has also diminished.

The patient was seen in pain management on October 11, 2010. She demonstrated antalgic limp and gait. She has a positive straight leg raise on her left this visit. Medication management is recommended. Delays in treatment approval are noted.

The patient was seen on December 13, 2010. She is complaining of numbness and tingling down to her left foot consistent with her disease state. Recommendation is again made for lumbar ESI. Her muscle spasms are a direct result of her pain and the body's response to pain. She has a positive straight leg raising sign.

Request for lumbar ESI was made on December 15, 2010.

Request for 1 Office visit for medications between 1/19/2011 and 3/20/2011 was considered in review on January 24, 2011 with recommendation for non-certification. The current report noted chronic back pain, buttock and leg pain and numbness and tingling into the left foot. The provider is considering LESI to limit Vicodin to 3-4 daily. She is also using Zanaflex. Per the reviewer, a clear rationale for an office visits was not provided. The independent reviewer opined her previous and current management (as of 8/3/10) were unreasonable. On 8/4/09 she presented with Waddell's signs and the treatments should have already stopped in 2005. The independent reviewer found that use of anti-depressants, narcotic analgesics and antispasmodic

medications were unnecessary for this patient. In this regard, a recent clinical assessment with a detailed physical examination was not provided for the review. There are no imaging studies provided as well to corroborate with the findings to establish the patient's pathology. A recent urine drug screen is also not presented for review to rule out issues of substance abuse or misuse. Given the mention of the patient's questionable pain complaints relating to the previous injuries and current physical and functional status that should need further medication use, a psychological evaluation is also not available to rule out or establish the presence of physical pain for this patient.

Appeal for an office visit for oral medication was submitted via fax on January 28, 2011.

Request for lumbar ESI at L5-S1 was considered in review on February 1, 2011 with recommendation for non-certification. Per the reviewer, the patient fell in xxxx and was diagnosed with lumbar disc displacement. She underwent several left shoulder surgeries, the last in April 2004. She underwent a lumbar ESI at L5-S1 on July 14, 2010. On August 30, 2010 she reported greater than 70% benefit with the LESI for her back, left buttock and left leg pain complaints. It was opined that she clearly had lumbar radiculopathy. Radiculopathy was supported by a positive straight leg raise, moderate sciatic notch tenderness and decreased pinprick sensation. She presented on December 13, 2010 for additional care. She is reporting numbness and tingling down her leg and foot. She was prescribed Vicodin and Zanaflex. As per the Required Medical Examination of 08/03/10 states that no continued chiropractic treatment, PT, work hardening, work conditioning, pain management, injections or diagnostic testing would still be considered healthcare reasonably required. No medical care should have been considered reasonable and necessary. No official diagnostic studies were submitted. An EMG reportedly showed radiculopathy. A peer discussion was attempted but not realized. Rationale for denial notes the patient's response to a prior LESI was not clarified. There is also no documentation that the patient has failed conservative management after the prior LESI.

The patient was examined on February 5, 2011. She complains of 6/10 left shoulder, neck and lower back pain. She also has pain in her knees and left wrist. She has 50% relief with medications. She has severe interference with ADLs. Her weight is 228 pounds. Left shoulder flexion is 100 degrees and abduction 80 degrees. She has positive impingement signs at the left shoulder. No instability is noted. She is neurologically intact except for slightly decreased grip strength bilaterally. Straight leg raise is negative. Left plantar flexion strength is 4/5. Sensation is intact. Medications were refilled.

Request for reconsideration 1 Office visit for medications between 1/19/2011 and 3/20/2011 was considered in review on February 1, 2011 with recommendation for non-certification.

Request was made for an IRO.

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

ODG: The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible.

The patient began with her current pain management provider in April 2010. She had shoulder problems prior to the current injury. She is overweight, deconditioned and has chronic pain complaints. She states the weak narcotic analgesic (hydrocodone), muscle relaxant and SSRI are not beneficial. She has been using hydrocodone, tizanidine and Lexapro for years with no reported benefit either in pain or function. Wellbutrin appears to have subsequently replaced Lexapro. According to the RME of August 2010 She began pain management in February 2008 and since that time has been prescribed Lexapro 10 mg once a day, Tizanidine 2 mg 1-2 every night and Hydrocodone 5/500 one every 8 hours. The patient admitted to the RME that she was not using all this medication and it was piling up. The RME found no evidence of active ongoing depression and Lexapro should have been weaned. There was also no evidence for muscle spasm and tizanidine should have been weaned. She had no benefit with the Hydrocodone and it should be weaned. The RME had evaluated the patient a number of times over the past six years and has repeatedly found the treatment to be unnecessary and unreasonable. The patient's treatment and response to treatment is fully summarized by the RME and the RME opinions appear to have merit. Per the RME, she does not have compensable depression. She does not have muscle spasm. The patient is overweight, addicted to tobacco and recalcitrant to all forms of treatments and medications. The diagnostic and clinical findings do not substantiate radiculopathy for this patient. No muscle spasms have been documented to support a muscle relaxant. Muscle relaxants are also not supported on a chronic basis. They are supported for acute exacerbations only. Weaning has been recommended immediately with Hydrocodone reduced to one tablet a day for two weeks then one tablet every other day for two weeks and then cessation. Tizidine can be stopped without weaning. Lexapro (or Wellbutrin) can be weaned over a 4-6 weeks period of time as described. She has been changed to Cymbalta (or W ellbutrin) but it remains unknown of she has actually started the medication and at what current dose. It is noted that anti-depressants are supported only for chronic neuropathic pain, a condition not substantiated for this patient. ODG also states that assessment of treatment efficacy when using anti-depressants should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. No such documentation is found for this patient.

The treatment is not supported by the clinical findings. Given the patient, per her own report, has a stockpile of medications and per the history and is not benefiting from the medications, weaning has been recommended. Additional visits for ongoing use of medications would not be indicated. The RME opinion that treatment since 2005 has not been reasonable has merit. The need

for ongoing office visits is not supported.

Therefore, my recommendation is to agree with the previous non-certification for 1 office visit for medications between 1/19/2011 and 3/20/2011

The IRO's decision is consistent with the following guidelines:

**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

The Official Disability Guidelines 02-17-2011 Lumbar Chapter: Office Visits:

Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.

ODG 02-13-2011 Pain Chapter:

Antidepressants for chronic pain

Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment

Bupropion (Wellbutrin®), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial (41 patients). (Finnerup, 2005) While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non-neuropathic chronic low back pain. (Katz, 2005) Furthermore, a recent review suggested that bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. (Dworkin, 2007) Side-effect profile: Headache, agitation, insomnia, anorexia, weight loss

Dosing Information: Neuropathic pain (off-label indication): 100 mg once daily, increase by 100 mg per week up to 200 mg twice daily.

ODG 02-13-2011 Pain Chapter:

Muscle Relaxants for Pain

Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. See the Low Back Chapter. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence.

ODG 02-13-2011 Pain Chapter:

#### CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:

(a) Are there reasonable alternatives to treatment, and have these been tried?

(b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?

(c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome?