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Notice of Independent Review Decision

DATE OF REVIEW: 3/16/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 80 hours of chronic pain management to the lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 80 hours of chronic pain management to the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Clinic and Clinic

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Clinic: indication for evaluation form (undated), 2/9/11 (update) initial assessment and eval report, 8/24/10 to 2/8/11 subsequent evaluation reports Rehab Facility, 12/3/10 PPE report, 10/15/10 thoracic only subsequent evaluation and 6/9/10 thoracic MRI report.

Clinic: 1/6/11 consultation report by MD.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker injured his spine on or about XX/XX/XXXX when he was pushing a cart loaded with objects and could not see objects in front of the rolling cart. Apparently, the cart hit an object and the cart bounced back causing the injured worker to flex and twist his spine. Records indicate that the cart injured his lower abdominal and inguinal area. He was referred to an emergency room and given analgesics. He subsequently began treatment with a physician who ordered four weeks of physical therapy for his lower back. According to available medical records, this physical therapy did not afford much in the way of relief. A MRI of the thoracic spine was performed on June 9, 2010. The thoracic spine was said to show no evidence of major abnormality. There was posterior annular bulging noted at the C6-7 level.

The injured worker apparently began treatment with M.D. on August 24, 2010. Dr. noted abdominal and inguinal tenderness, thoracic and lumbar paraspinal tenderness, and no neurologic deficits. Diagnoses of thoracic and lumbar strain were made and Dr. noted that there was pain radiating anteriorly to the lower thoracic and lumbar musculature as well as posteriorly down the left thigh. Dr. planned a return to physical therapy, Soma, Vicodin, and Fioricet.

Dr. saw the injured worker in follow-up on September 28, 2010, November 9, 2010, December 14, 2010, and February 8, 2011. Records indicate that Dr. recommended a MRI of the lumbar spine on September 28, 2010. This was denied by the carrier. There is no indication that x-rays of the lumbar spine were ever made and it is unclear as to whether or not the injured worker received physical therapy after the initial four weeks of therapy.

On December 3, 2010, the injured worker underwent a comprehensive evaluation. At that time, constant moderate to severe aching in the upper back was described, pain in the lower back was described, pain in the right and left sides of the neck was described, and discomfort in the left gluteal area was described. The physical examination results demonstrated limited range of motion of the lumbar spine, 1+ knee and ankle reflexes on the left, decreased sensation in the left L4-5 dermatome, 4/5 strength in the left gastrocnemius and soleus muscles, straight leg raising at 30° on the left and 45° on the right, and multiple myofascial trigger points. It was noted that the injured worker was functioning at a light duty capacity and his job required a medium duty capacity. A chronic pain management program was recommended.

On January 6, 2011, M.D., pain management specialist, evaluated the injured worker. He noted the mechanism of the injury and stated that the injured worker's inguinal and groin pain had resolved. He had had physical therapy for his lower back with minimal relief. He was complaining of pain listed at 8/10 and aching and numbness in the left upper extremity. He had poor sleep habits, decreased physical activity, and was said to be upset and depressed secondary

to pain. Dr. evaluation revealed that the thoracic and lumbar spine examination was normal with a negative straight leg raise. Dr. diagnosed cervical pain, cervical radiculopathy, a disk bulge at C6-7, and thoracic pain. Dr. recommended left C6-C7 and C7-T1 epidural steroid injections. These injections were denied.

A chronic pain management program was also denied on two occasions, initially because the mental health evaluation was felt to be inadequate and the documentation that the treating physician had ruled out all appropriate care for the chronic pain problem was not available. A second denial of the chronic pain management program was made on the basis that the medical record did not indicate that the previous methods of treatment for chronic pain had been unsuccessful. Also it was felt by the physician that there was insufficient evidence that options likely to result in significant clinical improvement had been clearly identified. There was also said to be a lack of adequate and thorough multidisciplinary evaluation.

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

Records indicate the injured worker developed psychosocial sequelae to his injury and a recommendation to see a pain management specialist and enter a chronic pain management program was made. The medical records provide information which is inaccurate, incomplete, or conflicting. There is a question about whether or not the injured worker's chronic pain is the cervical and arm pain indicated by the pain management specialist or the thoracic and lumbar pain indicated by his treating physician. According to the pain management specialist, the thoracic and lumbar spine examination was normal and he recommended treatment directed to the cervical spine.

Dr., the treating physician, however, in his notes suggests that the problem is in the thoracic and lumbar area with involvement of the left lower extremity. A thoracic MRI was performed, but no other imaging studies were done, not even, according to this record, x-rays of the lumbar spine. A lumbar MRI was recommend, but denied by the carrier. A diagnosis of radiculitis is mentioned in the medical record and the lower extremity neurologic examination was said to show weakness and sensory loss, but there is no evidence electrodiagnostic studies were ever performed or proposed to clarify the diagnosis.

The mental health evaluation does document mental health issues which would be consistent with a chronic pain syndrome, but the remainder of the medical record and evaluation are contradictory and indicate that the diagnosis for causation of the chronic pain is not yet established. That being the case, conflicting information about what the injured worker's complaints and physical findings actually are is presented. It would appear that the injured worker has not been thoroughly evaluated to establish a definitive diagnosis and rule out pathology that might best be treated by other treatment modalities. The medical

record does not present evidence of a thorough, consistent multidisciplinary evaluation and ODG Treatment Guideline criteria for the medical necessity of a chronic pain management program are not met. Therefore, the proposed treatment is found to be not medically necessary 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 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**