SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: May 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten Sessions of Work hardening; 80 hours. CPT Code: 97545 and 97546.

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

FAMILY PRACTICE
PRACTICE OF OCCUPATIONAL 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

The date of injury is xx/xx/xxxx. We are just under x years post injury. I am asked if ten sessions of work hardening for 80 hours is reasonable and necessary at this point in his care. The available medical records begin with a previous workers compensation report from October 21, 1998, that reveals the patient bumped his back on a blunt object, causing pain to the right upper back.

The medical assessment by M.D., on February 22, 1999, was lumbar strain.

I have Employer's First Report of Injury or Illness. The mechanism described is a slip and fall. The areas of injury are the head, back, right elbow, and left hip. It is noted the patient had been on the job for only a month at the time of his injury.

The emergency department assessment was right elbow contusion on April 29, 2009, at Medical Center. The working diagnosis was right elbow contusion and lumbosacral strain. The admitting physician was M.D. The discharge medications were Cyclobenzaprine and Darvocet.

There was no fracture or dislocation of the right elbow seen on initial x-rays. This was read by M.D., on April 29, 2009. Lumbar spine films revealed no fracture or dislocation. There were small calcifications overlying the lower pole of the kidney and possible renal stone. This was also read by Dr. on April 29, 2009.

The patient was returned to work in a restricted capacity within the U.S. Department of Labor light physical demand level as of April 30, 2009, with a diagnosis of lumbosacral strain, right elbow strain, and contusion of the back and elbow.

D.O., took the patient off work completely as of May 4, 2009.

I have the original MRI report of the right elbow from June 10, 2009, which, as previously discussed, revealed acute lateral epicondylitis with edema and inflammatory change surrounding the common extensor tendon from the humeral attachment distally.

There were six sessions of physical therapy requested for the summer of 2009.

There is a consultation with M.D. He stated this patient has no surgically amenable lesion. The patient was discharged from care as of July 27, 2009.

There is a functional abilities evaluation. This was performed on August 7, 2009. Dynamic lifting capacity placed the patient within the U.S. Department of Labor light physical demand level.

There is a physical therapy consultation from August 24, 2009. The goals for long-term and short-term functional recovery were set. This included support of psychotherapy and cognitive behavior and four sessions within U.S. Labor were approved.

The weekly follow-up visits with Dr. into August of 2009 revealed no material change in the patient's clinical condition. There was a referral made for further evaluation.

There is an evaluation by Ed.D., at Healthcare Systems. This would appear to be a psychological assessment dated August 24, 2009, approximately x months post injury. The mechanism of injury is

corroborated as a slip and fall on a wet floor, hurting the patient's back and right elbow. There were persistent pain complaints, despite a normal initial x-rays and normal MRI of the lumbar spine.

Electrodiagnostic studies revealed L5-S1 radiculopathy and C7-8 right-sided radiculopathy. It was recommended that spinal stenosis be considered, despite a normal MRI, and a diagnosis of right lateral epicondylitis.

It is noted that the patient had surgery on the elbow, and he was given three epidural steroid injections from January through August of 2009. The recommendation was for individual psychotherapy of four sessions.

The patient was continued off work by Dr. into September of 2009.

The patient had four sessions of behavioral health from October 6, 2009 through October 28, 2009. Psychotherapy with coping skills were the modalities employed.

I have the original surgical report of an epicondylar release and lateral collateral ligament repair. This was performed by M.D., on October 15, 2009. This was well tolerated without complications.

It is noted that 12 sessions of postoperative physical therapy were approved in the fall of 2009.

Results of a urine drug screen were seen to be inconsistent. Opiates were not detected on the urine screen of November 10, 2009. Mr. is the listed patient.

The patient was continued off work throughout this period.

The assessment of D.C., was lumbar strain and derangement of the right elbow as of follow-up visit on November 10, 2009. There were no neurosensory deficits described. His reflexes were symmetrical and brisk. His strength was 5/5. There was decreased range of motion of the right elbow seen. There was decreased volitional lumbar spine range of motion. The patient was placed on Zoloft for depression. There was improvement seen on December 11, 2009, per Dr..

The patient's physical demand level was once again in the light-to-light/medium physical demand level on his functional performance evaluation of December 9, 2009.

There were inconsistent urine findings as well from January 15, 2010, which were negative for opiates, despite their prescription for ongoing pain complaints.

There is an operative report from January 21, 2010. This is for a right elbow repair of the lateral collateral ligament. This was performed by Dr.. This was well tolerated without complications.

The patient underwent 12 sessions of physical therapy for postsurgical rehabilitation of the elbow in the winter of 2010, February and March. The reporting physician is Dr..

On March 2, 2010, the patient's symptoms of depression appear to improve on Zoloft. This is noted in an evaluation by D.O.

Hydrocodone and Hydromorphone were both positive on the patient's urine drug screen of March 6, 2010.

There is a repeat MRI of the right elbow from March 22, 2010. There was a small 3 mm loose body in the lateral compartment of the right elbow. There was moderate inflammatory change in and around the common flexor tendon and proximal musculature, extending from the lateral epicondyle distally over a length of 5.1 cm, with a small effusion. This was read by Dr.

There is an orthopedic consultation by M.D., at Sports Medicine. His impression was right elbow crepitation due to loose body versus soft tissue entrapment. The recommendation was for a referral to Dr. for evaluation to include possible arthroscopy.

There is a consultation by M.D., on April 26, 2010. The patient was placed on a course of Celebrex. Dr. recommended a conservative approach to include exercises of the involved elbow. There is a possible surgical intervention if there is no improvement with conservative modalities.

The serial follow-up evaluations with Dr. in the spring of 2010 revealed persistent pain in the 8/10 range on the visual analog pain scale due to no improvement.

An operative intervention was undertaken on June 25, 2010, by Dr. The procedure consisted of open excision of lateral synovium, scar tissue, and cartilage fragment of the right elbow. This was well tolerated without complications. The patient was placed in an elbow sleeve postoperatively.

There is a follow-up visit with Dr. on August 24, 2010, two months postoperatively. This revealed no material change in the patient's condition. The patient's pain remained in the upper portion of the visual analog scale at 7/10.

The patient's medications as of September 24, 2010, included Zoloft and Hydrocodone as necessary for pain. His pain was rated at 8/10. A chronic pain management program was recommended by Dr. due to persistent pain complaints. There were no focal neurological deficits in the lower extremities indicative of any ongoing or occult lumbar process. Despite previous electrodiagnostic studies which demonstrated L5-S1 radiculopathy, no sensory deficits were noted in the upper or lower extremities.

A urine drug screen on September 24, 2010, inconsistent findings of opiates were not detected which indicates the patient was not taking prescribed medications.

There is an emergency room visit at Medical Center on September 29, 2010, for pain complaints. X-rays of the right elbow were normal and read as such by M.D.

There is a follow-up visit with Dr. on October 14, 2010. The patient was seen to have returned after a substantial absence and missing an appointment. The patient relates being seen in the emergency room on September 25, 2010, after lifting a heavy object and feeling a sharp pain in his right elbow. Dr. recommended an urgent MRI to determine if there had been any change in his elbow.

There is a chronic pain management consultation from October 15, 2010. The patient was felt to be a good candidate for comprehensive pain management. There were ten days of chronic pain management recommended, per Ed.D., psychologist.

A physical performance evaluation from October 15, 2010, only placed the patient in the light/medium physical demand level, per D.C. Therefore, the patient had no change in his clinical function, despite all care to this point.

An MRI of the right elbow was performed. There was no acute abnormality seen. There was partial resection of the lateral epicondyle of the humerus with chronic tendinosis and scarring involving the proximal common extensor tendon and radial aspect of the capsule. The remaining elbow ligaments and tendons were within normal limits. There was normal articular cartilage and marrow signal intensity. This was read by M.D., as of October 29, 2010. There were no acute findings noted.

Dr. assessment of November 11, 2010, revealed normal range of motion of the right elbow to include flexion, extension, pronation and supination. The patient was discharged from care at that point. Dr. I felt the patient could return to work in an unrestricted capacity.

I have documentation of ongoing chronic pain management in the fall of 2010 and into the late winter of 2011.

There is a peer review performed on January 26, 2011. It was felt that a work hardening program for ten days, 80 hours, was neither reasonable nor necessary. The rationale given states that, "There was a lack of medical justification for ongoing and intensive tertiary treatment program given the stable status and lack of physical mismatch. There is no apparent barrier to progression to home exercise program/job search." This was appealed, and the request for the rationale states that "work hardening after completion of 160 hours of chronic pain management program." This was not felt to be reasonable or necessary as of February 21, 2011, by M.D.

Serial follow-up evaluations by Dr. did not delineate any sensory, motor, reflex, or atrophy changes in the lower extremities.

There is a physical performance evaluation from January 14, 2011, his third in as many months, which revealed no material change. The patient was still functioning in the light/medium physical demand level.

I have a clinical summary of this patient's care to date as of April 5, 2011. This included 20+ sessions of physical therapy, with the first being on May 5, 2009. This also included 20 sessions of a chronic pain management program. His surgical interventions included arthrocentesis aspiration and injection, July 6, 2009 and August 3, 2009; epicondylar release with lateral collateral ligament repair, October 15, 2009; right elbow repair of lateral collateral ligament, January 21, 2010; and open excision of lateral synovium, scar tissue, and cartilage fragment of right elbow, June 25, 2010. His medications included Flexeril, Darvocet, Amrix, Cyclobenzaprine, and Fexmid. His durable medical equipment included TENS unit, elbow brace, heating pad, garment belt sleeve, electrical stimulator, and pneumatic compressor.

There is a consultation from Medical Clinic. There was diffuse, non-specific pain over the upper spine. The patient's cervical range of motion was volitionally restricted, as was the elbow and the thoracolumbar spine. The assessment was sprain of the totality of the spine, internal derangement of the right elbow, and effusion of the right elbow. The patient was given an injection of Prednisolone 40 mg with Dexamethasone 40 mg, as well as Benadryl 50 mg, Ibuprofen, and Flexeril. The patient was continued on Darvocet for pain. Dr. recommended passive modalities to include heat, therapeutic exercises, and electrical muscle stimulation for functional recovery.

Dr. reviews an MRI of the lumbar spine, which was described as normal. An MRI of the right elbow revealed acute lateral epicondylitis with edema and inflammatory changes surrounding the common extensor tendon from the humeral attachment. According to the ODG Guidelines,

necessity for surgery for this type of injury is low. The substantial majority of the cases will spontaneously remit.

An MRI of the lumbar spine was performed. There were no findings; it was a completely normal MRI of the lumbar spine. This was read by M.D. There was no pathology, whatsoever.

Electrodiagnostic studies/EMG was read by M.D. He felt that they were suggestive of bilateral L5-S1 radiculopathy and either the C7 or C8 radiculopathy on the right, despite the fact that there was no corroboration of any nerve findings along these distributions on physical examination. There was a possibility of spinal stenosis with multiple nerve root impingement should be considered, but MRI of the lumbar spine revealed no such findings.
Three serial physical performance evaluations placed the patient within the U.S. Department of Labor light-to-medium physical demand level, which did not meet his job description of medium-to-heavy. In the physical performance evaluation, it describes that the patient had been working for five months at the time of injury instead of the previously one month as described; I am not sure which of these is the true statement.

I have results of a physical performance evaluation that reveals consistent inability to perform a light/medium physical demand level. The patient was only able to meet the physical demand level of light. There did not appear to have been any material change in his functional ability over the course of his physical performance evaluations.

Physical therapy to include manual therapy and therapeutic exercises was undertaken. Kinetic mobilization therapy was performed to the right elbow.

I have no further documentation.

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

I would have to concur with the adverse determination. At the current time, we are almost two years post injury. This patient has had the benefit of 20+ physical therapy sessions and 180 hours of chronic pain management. The patient has had three surgical procedures on his right elbow, and has been discharged from care by his treating orthopedic to return to work in an unrestricted capacity. Given the minimal pathology seen on the patient's most recent elbow MRI, factors other than his injury would seem to be the etiology for his failure to perform. As far as his lumbar spine is concerned, there has never been any pathology of his lumbar spine that could be the ongoing course of physical limitation. As such, there has been no material change in his condition throughout the two-year course of his care, and no medical improvement would be anticipated for ten sessions of work hardening. Therefore, I would have to concur with the previous adverse determination. Predicated in the ODG Guidelines is that there has to be some reasonable expectation of material change in the patient's clinical condition in order for this to be medically necessary.

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)**