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Notice of Independent Review Decision

DATE OF REVIEW: September 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management eight hours per day for ten days. CPT Code: 97799

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Diagnostic Imaging, 07/16/08, 08/04/09, 08/24/10, 09/08/10
- M.D., 06/14/10
- D.C., 05/24/10, 05/27/10, 06/01/10, 06/03/10, 06/14/10
- DWC-69, Report of Medical Evaluation, 09/10/10
- M.D., 09/10/10
- Healthcare Systems, 01/11/11, 02/11/11, 03/24/11
- Healthcare Systems, 02/11/11, 08/11/11, 08/16/11
- Healthcare Systems, 04/19/11, 08/03/11
- McGill Pain Questionnaire, 07/01/11
- Rehabilitation Center, 08/05/11, 08/15/11
- Direct, 08/08/11, 08/19/11

Medical records from the Provider include:

- Healthcare Systems, 04/18/11, 04/19/11, 08/03/11

PATIENT CLINICAL HISTORY:

I am asked to review the medical records to determine as part of an Independent Review Organization if the decision was upheld, overturned or partially overturned. The request is for chronic pain management at eight hours per day for ten days.

I have additional records for lumbar epidural steroid injection. This was performed by D.O., on July 16, 2009. There was a previous epidural steroid injection performed on June 4, 2009.

I have documentation of ongoing care to include electrical stimulation and vasopneumatic therapy for a diagnosis of lumbar disc derangement, knee strain, wrist strain, and myalgia as of May 24, 2010. This is reported by D.C. There is a total of five sessions for this therapy documented through June 14, 2010.

An MRI of the lumbar spine was performed. The upper lumbar levels L1-2, L2-3, and L3-4 were read as normal. There was a 1 mm disc protrusion with a 3 mm right paracentral component and mild central stenosis seen at L4-5. The right L5 nerve root may be impinged. There was a small disc protrusion of 2-3 mm in size at the L5-S1 level. This was read by M.D., on August 24, 2010.

There is an impairment rating by M.D. The patient is assigned a 4% whole person impairment rating as of September 10, 2010. She was felt to be at clinical maximum medical improvement as of this date. The clinical history was reviewed. The initial functional capacity evaluation performed the week of her injury revealed the patient was able to function within a light PDL and she later advanced to the medium category. There was a normal lumbar x-ray series as of June 21, 2010. There was a negative wrist x-ray as of June 21, 2010. There was a negative x-ray of the left knee. There was an incidental finding of osteochondroma. There was upper extremity nerve conduction velocities reported from July 6, 2010. The findings were consistent with carpal tunnel syndrome. The physical examination findings revealed no evidence of reflex or motor asymmetry. The working diagnosis was low back pain, left wrist sprain/strain, and left knee sprain/strain. Maximum medical improvement was felt to have been achieved. It was felt the patient had a 7% upper extremity impairment due to deficits in extension of the involved left wrist. The patient was felt to have findings consistent with DRE Category I of the lumbar spine. The patient had no functional deficits of the involved knee.

I have a functional capacity evaluation from April 18, 2011. The physical demand level was assessed as medium with a maximum of 25 pounds lifting occasionally. The calculated physical demand level was medium. The overall assessment states, "Based on history, exam findings and progress to date, it is my opinion she has reached a current physical demand level of medium. Based on history, exam findings and progress to date, it is my opinion she is a good candidate for work hardening." This is reported by D.C. The mechanism of injury is described as a slip and fell at work. The date of injury is May 20, 2010. Therefore, at this point, the patient would be almost 11 months post injury. The diagnosis is wrist sprain, leg/knee sprain/strain, and lumbar disc displacement.

I have what appears to be an initial consultation from Healthcare Systems on this patient dated April 19, 2011. The patient was referred by D.C., for evaluation. This is reported by L.P.C. The mechanism corroborated is that the patient slipped and fell on wet carpet. The patient's average daily pain is described as 7 out of 10.

There is an Healthcare Systems consultation from April 19, 2011, for evaluation of work hardening. The goals for short-term and long-term function were set by L.P.C.

The goals for functional improvement were set by Dr. The assessment was that there were decreased functional abilities that would be amenable to a chronic pain management program of eight hours per day at five days per week for two weeks as of August 3, 2011.

Electrodiagnostic studies read by M.D., were interpreted as bilateral L5 nerve root irritation of a chronic nature. There was no denervation. The left lower extremity appeared to be worse than the right. This appeared to be opposite of the imaging studies which revealed right L5 nerve root impingement, but there was no notation of a left nerve root impingement at this level.

There is a physical performance evaluation by D.C., on August 3, 2011. The recommendation is that the patient would benefit from ten days of chronic pain management as of that point, 15 months post injury.

I have a peer review from Ph.D., who reviews the assessments and evaluations for admission to a chronic pain management program. Dr. did not feel there was adequate clinical documentation to corroborate medical necessity of a chronic pain management program, as alternative causes of chronic pain had not been ruled out at that point. In reviewing the clinical history it was revealed that there was a previous back injury in 2009 treated with two epidural steroid injections. Dr. notes that the impression of listed pain disorder was inadequately corroborated on assessment.

There is a letter of request for reconsideration of a chronic pain management program by M.D., on August 15, 2011. In his clinical opinion, there was more than adequate psychological assessment performed to substantiate the necessity for a chronic pain management program, initial trial of ten sessions.

There were six sessions of individual counseling requested as of August 16, 2011.

The non-certification was upheld in a peer review assessment by Ph.D.

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

I would have to uphold the non-determination. From the imaging studies involved, there is evidence of degenerative disc disease at the lower two lumbar levels, worse at L4-5, with some evidence of minimal mechanical contact on the right L5 nerve root. However, there is no corroboration of any radiculopathy or radicular pattern. These would appear to be of a chronic nature and nothing that can acutely and directly attributable to the patient's uncomplicated slip and fall injury. There is evidence of a prior back injury for which the patient received two epidural steroid injections. As such, I cannot state at this point, 16 months post injury, that a chronic pain management program would be necessary for an uncomplicated slip and fall injury. The changes seen on imaging studies appear to be displacement, lumbar intervertebral disc of a chronic and degenerative nature, and therefore, pre-existent and possibly exacerbated, but not aggravated, by the mechanism described. As far as the Medical Disability Advisory is concerned, we are well beyond what would be considered a reasonable period of conservative care and maximum disability for treatment of a disrupted intervertebral disc of the lumbar spine, knee strain and wrist strain with myalgia.

1. In assessing the Medical Disability Advisor for knee injuries, uncomplicated strains of the anterior cruciate ligament or medial collateral ligaments, a maximum of 42 days is recommended for a return to even a very heavy physical demand level.
2. According to the Medical Disability Advisory, the period of maximum disability for return to even a Very Heavy Physical Demand Level for a diagnosis of uncomplicated lumbar strain is 56 days.
3. According to the Medical Disability Advisory, the period of maximum disability for return to even a Very Heavy Physical Demand Level for a diagnosis of displacement, lumbar intervertebral disk without myelopathy is 168 days.
4. According to the Medical Disability Advisory, the period of maximum disability for return to even a Very Heavy Physical Demand Level for a diagnosis of wrist sprain is 42 days.

There is a poor causal relationship between the mechanism of injury, the diagnostic studies, the listed diagnoses and the persistent nature of the complaints.

1. Electrodiagnostic studies of the upper extremities were interpreted as demonstrating bilateral carpal tunnel syndrome in the absence of any clinical findings on examination.
2. There is poor concordance between the imaging studies (1 mm disc protrusion with a 3 mm right paracentral component and mild central stenosis seen at L4-5. The right L5 nerve root may be impinged. There was a small disc protrusion of 2-3 mm in size at the L5-S1 level.) and the lower extremity electrodiagnostic studies (bilateral L5 nerve root irritation of a chronic nature. There was no denervation. The left lower extremity appeared to be worse than the right.)
3. The imaging studies of the knee and wrist were normal.

Diagnostic imaging studies have not corroborated any acute pathology that could be attributable to a slip and fall injury. The ODG recommends causality determination, which has not been affirmed.

The ODG also recommends early intervention (within 3-6 months of injury) in pain management, as the therapeutic value of the therapy declines as time from injury increases. Therefore, 16 months post injury, there would be a low expectation of material change in the clinical condition, given, the poor causal relationship between the mechanism of injury and the ongoing pain complaints, the minimal findings on imaging, and the non specific nature of the pain complaints.

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)