



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 4/3/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a chronic pain management program 5x/week x 2 weeks 97799, right foot.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of a chronic pain management program 5x/week x 2 weeks 97799, right foot.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Pain Center .

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Pain: 2/3/12 script for Pain Rehab program, 2/22/12 preauth request, 2/22/12 appeal for services letter, 2/14/12 preauth request, 2/9/12 request for services letter, 2/20/12 LMN for CPM program, office notes 12/5/11 to 2/3/12 by MD, and MD's report of 1/5/12.

: 3/6/12 denial letter, 2/17/12 denial letter, SOAPP assessment request by , MD, 2/7/12 preauth request, 3/21/11 right ankle MRI report, 2/28/11 right foot MRI report, 5/18/11 report by MD, EMG/NCV interpretation 5/28/11, and 5/18/11 exam report by Dr.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This worker was injured on xx/xx/xx. According to the record, a forklift ran over the right lower extremity from the foot all the way to the hip. It is unclear as to exactly what body part was injured although throughout the record, there is mention of injury to the foot and ankle. MRI of the right foot performed on xx/xx/xx showed extensive bone contusion of the second through the fifth metatarsal bones, extensive soft tissue edema surrounding the metatarsals, and small joint effusions. An MRI of the right ankle performed on March 21, 2011 showed a stress injury to the right third metatarsal and medial and lateral malleoli, tenosynovitis of the flexor hallucis longus, posterior tibial, and flexor digitorum longus muscles, and a tear of the posterior band of the talofibular, talocalcaneal, and calcaneofibular ligaments.

EMG and nerve conduction studies performed by M.D. on May 18, 2011 indicated that the right lower extremity study was within normal limits. Dr. gave the opinion that the injured worker's symptoms were consistent with a reflex sympathetic dystrophy.

On December 5, 2011, , M.D. evaluated the worker and noted that he had injured his foot on xx/xx/xx. Apparently, a spinal cord stimulator had been inserted on October 13, 2011 and the worker had had postoperative physical therapy. Dr. assessment was that the injured worker had had a closed fracture of the right second toe, and a talofibular sprain or strain. Dr. also felt that the injured worker had a complex regional pain syndrome.

There are therapy notes from December 12, 19, 21 and 22, 2011. On December 22, Dr. indicated that physical therapy was not providing relief to the patient and recommended that the injured worker be referred to a pain management specialist and that physical therapy be discontinued. On January 5, 2012, M.D. performed a Designated Doctor Evaluation. Dr. noted that the injured worker had had 12 physical therapy sessions which had not given relief. Lyrica also did not relieve the pain. Dr. note indicates that the injured worker had been treated with Amitriptylene, Neurontin, hydrocodone, and Lidocaine patches. Dr. in his

capacity as a Designated Doctor, diagnosed a crush injury to the right foot and ankle with chronic pain. His evaluation does not mention a complex regional pain syndrome. Dr. did not feel that the injured worker was at maximum medical improvement because he had a lot of misconception and suffered from a significant amount of fear avoidance. Dr. recommended consideration of a multidisciplinary pain management program.

On February 9, 2012, the injured worker underwent assessment for a chronic pain management program. The evaluation was signed by a psychiatrist, M.D. Dr. indicated that the injured worker had a chronic pain syndrome with psychosocial sequelae and would need a chronic pain management program.

There are two Letters of Adverse Determination, one on February 17, 2012 indicating that there was "no clear documentation of an absence of other options likely to result in significant clinical improvement" and a second Adverse Determination dated March 6, 2012 because of lack of documentation of efficacy of physical therapy and lack of a psychological evaluation.

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

According to available medical records, this worker was injured in a work related accident on xx/xx/xx. The record is unclear as to exactly what body parts were actually injured. Apparently, there was at least a crush type injury to the right ankle and foot and possible injury to the knee and hip area. The injured worker was evaluated with MRI studies and electrodiagnostic studies. He was extensively treated with at least 12 physical therapy sessions which, according to the medical record, did not provide any relief. He received multiple medications including at least Amitriptyline, Neurontin, hydrocodone, Lidocaine patches, Lyrica, and Alprazolam. He had a spinal stimulator inserted on October 13, 2011.

According to the worker's treating physician, M.D., and his latest Designated Doctor, M.D., the injured worker has received a full evaluation and treatment program and there are no other options for treatment which might provide significant clinical improvement other than a chronic pain management program. The injured worker has been thoroughly evaluated. The evaluation indicated that the worker has physical problems and injury resulting in a chronic pain syndrome with limited function of the right lower extremity. He has been extensively treated as noted in the record but has failed to adequately control his pain to allow him to return to work and resume his normal everyday activities.

There is indication of significant psychosocial compromise. The record indicates that the worker is interested in participating in the chronic pain management program and recognizes the implications of doing so. Negative predictors of success have been identified. There is documentation in the medical record that

the injured worker did receive extensive treatment which did not result in adequate pain control. He has received a psychological evaluation signed by Dr., a psychiatrist, who indicates that there are psychosocial sequelae to this injury. Dr. documents Axis I through V diagnostic formulations in her assessment for a pain management program. This injured worker does meet ODG Treatment Guidelines for a chronic pain management program five times a week for two weeks. Therefore, the requested program is medically necessary at this time according to the records provided.

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)**