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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 7/2/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 97799 Chronic Pain Management Program x 80 hours.

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 97799 Chronic Pain Management Program x 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Clinic (PRC) and Group.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Group: 6/19/12 letter by, 6/19/12 IRO summary report, CPM ODG section, DWC 1 dated 3/30/11, 3/29/11 associates statement, 3/30/11 release of records form, 3/30/11 office notes from, various DWC 73 forms, 3/31/11 initial report from PRC, 3/31/11 to 5/31/12 medication prescriptions, 4/6/11 to 5/31/12 office notes from PRC, 4/14/11 to 9/16/11 handwritten notes by Dr. 5/2/11 radiology report, 5/18/11 to 1/30/12 EMS prescriptions, prescription and LMN, 5/11/11 to 6/1/11 CMT notes, 6/2/11 MRI report, MMT script by Dr., 7/28/11 MMT report, 7/28/11 office notes by Dr., 8/30/11 cervical ESI report, 9/2/11 neurodiagnostic testing report, 9/14/11 report by MD, 10/14/11 moist heat prescription, 10/31/11 myelogram with post

CT(cervical) reports, 2/8/12 LMN, RYCO decision dated 2/17/12, MD report 3/21/12, 5/9/12 behavioral eval report, 5/10/12 FCE report, 5/21/12 denial letter, 5/16/12 precert request, 6/6/12 denial letter, 5/30/12 reconsideration request, and 5/25/12 reconsideration request letter.
PRC: 6/26/12 letter by Dr..

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker was injured on xx/xx/xx while attempting to pull a box of sunflower seeds from a tall, 12 foot pallet. Records indicate that a box of Trident weighing approximately ten pounds was on top of the seeds. When the sunflower seeds were moved, the box apparently fell striking the injured worker on the forehead. She experienced a “burning” type pain in the neck at the time of onset.

The injured worker was seen at on xx/xx/xx and began treatment with M.D. on xx/xx/xx. Dr. has continued to provide care throughout the patient’s post injury course. His initial evaluation yielded diagnoses of cervical radiculitis, thoracic sprain/strain, and headaches. He recommended physical therapy, Flexeril 10 mg b.i.d. and suggested that the injured worker was disabled and should not be working. Records indicate that the worker received ten physical therapy sessions between April 6, 2011 and May 4, 2011. She underwent five chiropractic spine manipulations between May 11, 2011 and June 1, 2011. According to Dr. notes, the injured worker’s pain increased during that treatment program. Medications prescribed included Motrin 600 mg b.i.d., Flexeril, 10 mg b.i.d., and Ultram.

X-rays of the cervical spine performed on May 2 showed degenerative disk disease at C6-7 with loss of cervical lordosis. An MRI of the cervical spine performed on June 2 reportedly showed multilevel disk protrusions with some lateralization to the right at C4-5, C5-6, and T3-4.

On July 28, 2011, the injured worker was evaluated by M.D., an orthopedic surgeon. Dr. recommended epidural steroid injections and these were performed by M.D. on August 30, 2011. The cervical epidural steroid injections were performed at C7-T1. Dr. continued to record that the patient was reporting neck pain varying from 7 to 9 on a scale of 0 to 10. He prescribed Soma and Norco in addition to Flexeril.

On September 2, 2011, , DC, performed electrodiagnostic studies which were said to be consistent with bilateral C7, C8 and T1 radiculopathies. On September 14, 2011, , M.D. evaluated the patient and recommended a discectomy and anterior cervical fusion at C5-6 and C6-7. On October 31, 2011, a myelogram and CT scan were performed. These reportedly showed disk protrusions with reduced filling of the right C6 and C7 nerve roots. On December 6, Dr. noted that the patient was complaining of left shoulder stiffness resulting from her

cervical pain and pain radiating to the left arm. He recommended physical therapy for the left shoulder in addition to the anterior cervical fusion at C5-6 and C6-7.

On March 21, 2012, M.D., an orthopedic surgeon, saw the injured worker for a second opinion regarding surgery. Dr. diagnosed a herniated cervical disk, a cervical radiculopathy, and adhesive capsulitis of the left shoulder. He recommended anterior cervical discectomy and fusion at C5-6 and C6-7 in addition to an MRI of the left shoulder. Apparently, both the surgery and the recommended MRI of the left shoulder were denied.

On May 10, 2012, the injured worker had a work capacity evaluation which demonstrated that she was functioning at a sedentary PDL. It was noted that her work required a heavy PDL. She underwent a Behavioral Evaluation which showed a BDI of 29 and a BAI of 27. The evaluator noted that the injured worker was unrealistic about the possibility of obtaining total pain relief. A chronic pain management program was recommended. There are two Letters of Denial of the recommended chronic pain management program from M.D. dated May 21, 2012 and June 6, 2012.

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

This worker was injured on xx/xx/xx when a ten-pound box struck her on the forehead and apparently caused her to extend her neck. She began complaining of neck pain with upper extremity symptoms. She was evaluated by multiple physicians, but the descriptions of those evaluations do not match. As an example, Dr. when he performed orthopedic consultation on September 14, 2011 reported that upper extremity deep tendon reflexes were 2+ on the right and 1+ on the left. Dr., when he evaluated the injured worker indicated that upper extremity reflexes were 2+ on the left, 2+ at the right biceps, and 1+ at the triceps and brachioradialis. There are a variety of descriptions of sensory loss. There is no evidence of atrophy recorded in the medical record though diagnoses of radiculopathy were made. The patient reportedly developed problems with her left shoulder described as “adhesive capsulitis” but there is no evidence in the medical record that x-rays were ever taken. An MRI was recommended but denied. There is no indication that the injured worker received any specific treatment for the left shoulder other than nonsteroidal anti-inflammatory medications and muscle relaxers.

ODG Guidelines state that a candidate for a chronic pain management program should have an adequate and thorough multidisciplinary evaluation. The physical examination should rule out conditions that require treatment prior to initiating the program. The medical records presented for review do not provide evidence of a thorough multidisciplinary evaluation which resulted in clearly identified, complete, and consistent description of the injured worker’s physical findings, diagnoses, and problems to be addressed. The injured worker has

been evaluated by a number of physicians with no consistent description of physical findings leading the reviewer to question the existence of and/or extent of actual pathology.

According to the available medical records, the left shoulder (which is apparently a pain generating source) has had no x-rays and the adhesive capsulitis has apparently not been addressed with therapy or consideration of other usual treatment such as injection or possibly even manipulation. The injured worker is reportedly using electrical stimulation and a heating pad and is on extensive medications including nonsteroidal anti-inflammatory medication, muscle relaxers, analgesics, and antidepressants. There is no indication that she is on an active therapy program to address her limited mobility and deconditioning.

The reviewer notes the record is not clear if the injured worker had any psychological counseling to address her psychosocial dysfunction. Surgery has apparently been denied, but the record does not truly document that there is an absence of other options which might result in significant clinical improvement. This medical record does not indicate that this injured worker meets criteria for the prospective medical necessity of a chronic pain management program times 80 hours. Therefore, it 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)