IRO America Inc.

An Independent Review Organization
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facsimile transmittal

To:		Fax:	512-804-4868
From:	IRO America	Date:	3/27/2008
Re:	Final Decision Letter	Pages:	8
Cc:			

☐ Urgent ☐ For review ☐ Please ☐ Please reply ☐ Please recycle

IRO America Inc.

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February 9, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:	___
TDI-DWC #:	___
MDR Tracking #:	M2-06-0565-01
IRO #:	5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

1. Medical Dispute Resolution Request.
2. Cervical MRI report, 9-9-04.
3. Epidural Steroid Injection report, 11-17-04.
4. Operative report, 3-1-05.
5. Medical reports from the Hillcrest Baptist Medical Center, 3-18-05, 4-5-05, 5-3-05.
6. Cervical x-ray report, 5-27-05.
7. Narrative Reports from Cody Doyle, D.C., 6-14-05, 7-28-05, 9-13-05.
8. SOAP notes from Cody Doyle, D.C., 6-15-05 through 9-13-05, totaling 29 visits.
9. Therapeutic Procedures reports, 6-15-05 through 9-9-05, totaling 26 sessions.
10. Initial Behavioral Medicine Consultation, 7-25-05.
11. History and Physical Work Hardening report from S. Crockett, D.O., 10-6-05.

12. Work Hardening Daily Notes, 10-15-05 through 11-10-05, totaling 17 sessions.
13. Review of Medical History and Physical Examination report by S. Holtzman, MD, 10-14-05.
14. FCE and Detailed Narrative Report, 11-7-05.
15. History and Physical for Chronic Pain report by S. Crockett, D.O., 11-17-05.
16. Request for Chronic Pain Management and Plan & Goals of Treatment report, 11-29-05.
17. Utilization Review Determination, 12-5-05.
18. Reconsideration for Chronic Pain Management report, 12-12-05.
19. Utilization Review Determination, 12-15-05.
20. Requester's Position Regarding Pre-authorization report, 12-19-05.

CLINICAL HISTORY

1984: According to the behavioral assessment dated 7-25-05, The Patient saw a psychotherapist and psychiatrist for one year and was prescribed antidepressants and anti-anxiety medication for approximately 12 months. The Patient's symptoms improved; therefore, she discontinued therapy.

_____: The Patient was on a smoke break when she attempted to sit down and missed the bench resulting in an axial compression type injury and reported cervical pain. The Patient worked for EMSI for 16 years. She was managed medically.

9-9-04: Cervical MRI dated 9-9-04 denoted central disc protrusion at C6-C7 with flattening of the spinal canal and cord at the C5-C6 and C6-C7 levels, foraminal narrowing at C6-C7 bilaterally secondary to disc bulging and joint hypertrophy with moderately severe foraminal narrowing bilaterally at C5-C6 and on the left at C4-C5, and focal hyperdensity of the left side of the cervical spinal canal at C5-C6, which may represent myelomalacia.

11-17-04: C7-T1 epidural steroid injection was performed.

3-1-05: C4-C5, C5-C6, and C6-C7 anterior cervical discectomies with allograft bone fusion instrumentation was performed.

3-18-05: The Patient was evaluated by Walter Lindner, M.D. The Patient was taking Neurontin daily and hydrocodone times two every four to six hours. The Patient reported her sleeping was somewhat sporadic and was waking twice a night. Physical examination revealed pain with palpation in the cervical paraspinal musculature, equal grip strength, and good strength with internal/external rotation.

4-1-05: Dr. Oishi placed a bone growth stimulator.

4-5-05: The Patient was evaluated by Richard Scott, D.O. The Patient reported a numerical pain scale of 7/10 with an 8/10 at worst. The Patient was taking seven hydrocodone per day. She was also taking Soma in the evening. The Patient was not working. Mobic was prescribed and Dr. Scott felt The Patient should be weaned off hydrocodone.

5-3-05: The Patient was taking three hydrocodone per day. Her numerical pain scale was 4-5/10.

5-27-05: Cervical x-rays revealed postoperative changes.

6-14-05: The Patient was evaluated by Cody Doyle, DC. The Patient reported headaches, neck pain, low back pain, left upper extremity pain, right upper extremity pain, and right upper extremity tingling, and numbness in the hand. The Patient reported a pain scale of 5/10. Symptoms were reported as occurring on a frequent basis. The Patient reported her previous job

was a sedentary position to include sitting at a desk and on a stenotype chair. Review of systems demonstrated fatigue, weakness, night sweats, headaches, nervousness, anxiety, depression, and mood swings. NDI was 48%. Physical examination revealed spastic musculature and trigger points in the cervical spine. Positive orthopedic tests included cervical compression, shoulder depression, soto hall, and cervical distraction. The treatment plan included passive and active therapy. Goals included normalizing joint motion, reducing muscle spasm and tightness, reducing pain, improving mobility and physical capacity, and returning to normal work and activities of daily living.

7-25-05: A Behavioral Medicine Consultation was performed. The Patient reported an average pain scale of 7/10 with episodes of 10/10. She reported aching, burning, and stabbing pain in the neck and upper back with numbness in her right arm and hand. She reported significant interference with recreational and social activities. Multiple pain behaviors were demonstrated. Medications included Xanax, Diovan, Hydrocodone, Soma, and aspirin. The Patient was tearful, depressed, and anxious. She reported mood swings and difficulty with concentration. She reported insomnia and receiving approximately 5 hours of interrupted sleep per night. Irritability, restlessness, and frustration was rated 8/10. Muscle tension and depression was rated 9/10. Nervousness and worry was reported 10/10. GAF was 55. BDI was 30. BAI was 38.

7-28-05: Re-evaluation was performed by Cody Doyle, DC. The Patient reported sharp, constant head pain rated 6/10, severe neck pain and severe upper back pain. She reported severe bilateral shoulder pain and constant moderate right upper extremity numbness and pain, and severe right hand numbness. HSQ questionnaire demonstrated deterioration in functioning emotional, mental health, and health perceptions. Energy, pain, and social functioning were unchanged. Physical functioning improved. NDI was unchanged at 48%. She actually deteriorated in regards to headaches, concentration, driving, and sleeping. Cervical flexion was 47°, extension 12°, left rotation 47°, and right rotation 38°. Flexion strength was 6 pounds, extension 8 pounds, and lateral flexion 6 pounds and 8 pounds.

6-15-05 through 9-9-05: The Patient participated in chiropractic rehabilitation under the auspices of Cody Doyle, DC. The therapeutic procedures reports indicated The Patient participated in 1 hour to 2 hours and 25 minutes of 1-1 guided exercise to include resistance training, aerobic training, stretching exercises, and range of motion exercises, cervical strengthening, shoulder strengthening, upper back strengthening, and specific instructions with a home exercise program.

9-13-05: Re-evaluation was performed by Cody Doyle, DC. This examination occurred after approximately 25-30 sessions of chiropractic/physical therapy treatment. The Patient reported a numerical pain scale of 6/10. When compared to the 6-14-05 chiropractic evaluation, HSQ testing revealed deterioration in social functioning, functioning emotional, mental health, energy/fatigue, and general health perceptions. Pain was unchanged. Physical functioning improved. Major depression was still present. NDI was unchanged at 48%. Personal-care was unchanged and recreational activity deteriorated. Palpation elicited spastic paraspinal musculature and trigger points. Positive orthopedic tests included shoulder depression, soto hall, and cervical distraction. Cervical flexion was 45°, extension 6°, right rotation 0°, and left rotation 14°. All these ROM findings were worse than previously tested on 6-14-05. Flexion strength was unchanged and lateral flexion strength deteriorated.

10-5-05: FCE demonstrated The Patient was performing at a sedentary physical demand level

According to a report from Phil Bohart, LPC dated 11-19-05; The Patient participated in 10-sessions of individual psychotherapy, biofeedback PPA, and biofeedback training. The recodes provided did not include specifics of the program nor did it indicate when this was performed.

10-6-05: S. Crockett, D.O. recommended a Work Hardening Program.

10-10-05 through 11-10-05: The Patient participated in a 17 session interdisciplinary Work Hardening Program. On 10-10-05, The Patient reported a numerical pain scale ranging between 4/10 and 5/10. On 10-20-05, The Patient reported a numerical pain scale of 7/10. On 11-1-05, The Patient reported a numerical pain scale of 7-8/10. On 11-9-05, The Patient reported a numerical pain scale of 6/10.

10-14-05: The Patient was evaluated by S. Holtzman, MD. The Patient reported neck pain and numbness in her upper extremity. Numerical pain scale was 4-5/10 and occurring on a continuous basis. The Patient was given 5% WPI.

11-7-05: FCE was performed. Numerical pain scale was 6/10. Two hand and one hand lift values were nonphysiologic. Push and pull values were also nonphysiologic. Testing demonstrated an inability to crawl, climb ladders, stair climb, kneel, and squat. She also reported difficulty with balancing and leg control. These findings are extremely inconsistent with the cervical injury. Cervical flexion was 23°, extension 42°, right rotation 42°, and left rotation 58°. Arm lift percentile was 8%, near-lift 2%, and pull 1%. Shoulder lift was 1%-tile and carry was 1%-tile. The Patient qualified for sedentary work.

11-17-05: Dr. Crockett recommended a Chronic Pain Management Program.

11-29-05: Phil Bohart, MS, CRC, LPC, QMHP recommended a Chronic Pain Management Program. Cervical flexion was 22°, extension 41°, right rotation 45°, and left rotation 60°.

12-5-05: The Chronic Pain Management Program was denied by Donald Murphy, D.C. stating “there is no evidence in the scientific literature that CPMP are helpful for individuals with neck pain.”

12-12-05: Phil Bohart asked for reconsideration on the requested Chronic Pain Management Program.

12-15-05: Another request for Chronic Pain Management was denied by Gary Jacob, D.C. stating The Patient had already explored physical conditioning, a PDL goal was not reported, nor was there a job for the treatment goal to be set to.

12-19-05: Tracey Duran, MS, LPC requested medical dispute resolution regarding the 20-session Chronic Pain Management Program previously denied by Dr. Murphy and Dr. Jacob.

DISPUTED SERVICE(S)

Under dispute is the prospective, and/or concurrent medical necessity of 20 sessions of chronic pain management.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

First, I believe additional treatment including Chronic Pain Management would be redundant. The Patient participated in a protracted course of active rehabilitation/functional training, 10 sessions of individual psychotherapy, biofeedback, and 17 sessions of

interdisciplinary Work Hardening. Individual psychotherapy specifically addresses behavioral issues, biofeedback specifically addresses tension and anxiety issues, and Work Hardening includes progressive functional and physical conditioning, behavioral and attitudinal treatment, and vocational guidance and instruction.

Second, Chronic Pain Management Programs include a great deal of functional/physical conditioning. This patient has participated in a protracted course of in-office chiropractic rehabilitation to include a progressive supervised exercise program (1-2 ½ hours of 1-1 guidance) and a progressive home exercise program. Additionally, The Patient participated in 17 sessions of physical conditioning using real or simulated work activities (WHP) to improve tolerance to work and daily activities. Additional implementation of active functional restoration type treatment cannot be supported.

Third, the National Guideline Clearinghouse maintains chronic pain syndrome patients are best treated in an integrated interdisciplinary program including multiple providers such as physicians, psychotherapist, PT/OT, vocational counselors, and specialty consultants.

Fourth, the National Guideline Clearinghouse indicates claimants should be considered for programs if there is a reasonable chance of showing significant improvement. In The Reviewer's medical assessment, The Patient does not have a "reasonable" chance of showing "significant" improvement. Despite protracted rehabilitation efforts, biofeedback, individual psychotherapy, and in interdisciplinary Work Hardening Program, The Patient continues to report significant pain levels, significant self perceived disability (48% NDI), poor physical conditioning (Sedentary PDL), depression and anxiety (BAI and BDI), and abnormalities with psychological, social, and occupational functioning (GAF

Fifth, the documentation fails to reasonably indicate additional interdisciplinary treatment would relieve the effects of the injury, objectively promote recovery, or enhance the ability of The Patient to return to work.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
IRO America, Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Cc: ___

Dr. Cody Doyle
Fax: 254-772-6584

Injury One Treatment Center
Attn: James Odom
Fax: 214-692-6670

Commerce & Industry Ins. / FOL
Attn: Katie Foster
Fax: 512-867-1733

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or The Patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 9th ay of February, 2006.

Name and Signature of IRO America Representative:

Sincerely,
IRO America, Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer