



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M2-06-1379-01
NAME OF REQUESTOR: Positive Pain Management
NAME OF PROVIDER: Harold Lewis, D.O.
REVIEWED BY: Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 06/21/06

Dear Positive Pain Management:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Anesthesiology, Pain Management, and Pain Medicine and is currently listed on the DWC Approved Doctor List.

M2-06-1379-01

Page Two

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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 carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An MRI of the lumbar spine interpreted by John R. Mireur, M.D. dated 04/21/03

An EMG/NCV study interpreted by Jill E. Heytens, M.D. dated 09/03/03

A lumbar myelogram and post myelogram CT scan interpreted by Gordon A. Witwer, M.D. dated 09/16/03

A medical review form from Paul Strube, D.C. dated 07/02/04

A Benefits Review Conference (BRC) report from Barbara McWilliams dated 08/16/05

A Decision and Order letter from Gary L. Kilgore dated 08/16/05

A letter from Dorian E. Ramirez, Director of the Texas Department of Insurance (TDI), dated 01/17/06

An evaluation with Casey G. Cochran, D.O. dated 02/03/06

Evaluations with Harold D. Lewis, D.O. dated 02/08/06, 02/09/06, 02/10/06, 02/11/06, 02/13/06, 03/20/06, 04/03/06, and 05/09/06

An MRI of the lumbar spine interpreted by Chester Y. Smith, D.C. dated 02/22/06

Letters of denial from Corvel dated 02/22/06, 04/20/06, and 04/28/06

A pain evaluation with Dr. Lewis and Tim Boggs, M.D. dated 04/10/06

A Physical Performance Evaluation (PPE) with Ricky A. Cain, M.P.T. dated 04/11/06

A Designated Doctor Evaluation with Albert C. Molnar, M.D. dated 04/13/06

A letter of appeal from Ellen Duncan, M.D., Dr. Boggs, and Ron Ziegler, Ph.D. dated 04/24/06

A letter of denial from an unknown provider (no name or signature was available) dated 04/27/06

A letter of dispute from Dr. Duncan, Dr. Boggs, and Dr. Ziegler dated 05/02/06

A Designated Doctor Evaluation with Greg Terry, M.D. dated 05/17/06

M2-06-1379-01

Page Three

Clinical History Summarized:

An MRI of the lumbar spine interpreted by Dr. Mireur on 04/21/03 revealed mild spondylosis and facet hypertrophy at L4-L5 and L5-S1 with a diffuse annular bulge and suspected tear at L4-L5 and foraminal narrowing at L5-S1. An EMG/NCV study interpreted by Dr. Heytens on 09/03/03 was unremarkable. A lumbar myelogram CT scan interpreted by Dr. Witwer on 09/16/03 revealed mild degenerative changes at L3-L4 and L4-L5 with a mild disc bulging at L4-L5 and L5-S1. On 07/02/04, Dr. Strube felt chiropractic treatment with Jerry Richardson, D.C. starting on 06/03/04 was not related to the work injury. A Decision and Order from Mr. Kilgore ordered payment for all injuries except a right eye injury on _____. On 02/03/06, Dr. Cochran disagreed with Mr. Kilgore. He recommended further treatment only including a home exercise program and a return to work. An MRI of the lumbar spine interpreted by Dr. Smith on 02/22/06 revealed a disc extrusion at L4-L5, a broad based disc bulge at L5-S1 with annular tears, a large annular tear at L3-L4, and arthrosis of the posterior joints through the lumbar spine. On 02/22/06, Corvel provided notes of denial for a lumbar MRI. On 04/03/06, Dr. Lewis referred the patient to pain management. On 04/10/06, Dr. Lewis, Dr. Boggs, and Dr. Ziegler recommended a 20 day pain management program. A PPE with Mr. Cain on 04/11/06 again determined the need for a pain program. On 04/13/06, Dr. Molnar placed the patient at Maximum Medical Improvement (MMI) as of 11/11/03 with a 20% whole person impairment rating. Corvel provided notes of denial for the pain management program on 04/20/06 and 04/28/06. On 04/24/06, Dr. Duncan, Dr. Boggs, and Dr. Ziegler wrote a letter of appeal for the pain program and a letter of dispute on 05/02/06. On 05/09/06, Dr. Lewis noted the patient had a BRC the next day. On 05/17/06, Dr. Terry felt the patient was not at MMI.

Disputed Services:

Twenty days of a chronic pain management program

Decision:

I disagree with the requestor. The 20 days of a chronic pain management program would be neither reasonable nor necessary.

Rationale/Basis for Decision:

This patient allegedly was injured at work on _____, after he fell from a ladder and the ladder fell, striking him in the face.

M2-06-1379-01

Page Four

The patient underwent lumbar MRI on 04/21/03, one month after the alleged injury, which demonstrated mild facet hypertrophy at L4-L5 and L5-S1, no disc herniation, no spinal stenosis or neural compression, and disc dehydration at L3-L4 and L4-L5.

The patient also underwent electrodiagnostic studies on 09/03/03, which were specifically negative for any evidence of lumbosacral radiculopathy.

A myelogram was also performed on 09/16/03, confirming the MRI results of mild non-compressive disc bulges and degeneration, but no disc herniation, spinal canal stenosis, foraminal stenosis, or spinal cord or nerve root impingement. The CT scan following the myelogram demonstrated similar results.

The patient subsequently underwent two epidural steroid injections (ESIs) with Dr. Malizzo, neither of which provided any clinical benefit.

The patient was evaluated by Dr. Cochran on 02/03/06. In that evaluation, Dr. Cochran noted evidence of multiple positive Waddell's signs (seven), as well as multiple non-physiological physical examination findings and evidence of symptom magnification. He found no credible evidence of objective support for the patient's complaints of erectile dysfunction, headaches, or eye injury. He noted the patient's subjective complaints did not match any of the objective imaging study findings and that there was "no evidence that this individual experienced anything more than a soft tissue injury". He further noted the presence of the seven positive Waddell's signs and the physiologically impossible relationship between the patient's subjective complaints and the physical examination that he performed. He recommended against any further treatment whatsoever, stating "continued medical attention will only serve to perpetuate the subjective complaints and reinforce an environment of chronic pain". He also noted in the physical examination that there was no physiologic evidence of distress such as elevated heart rate, blood pressure, or respiratory rate.

The patient then began treatment with Dr. Harold Lewis, a family practitioner, on 02/08/06. In the initial evaluation, Dr. Lewis stated the patient had bilateral lumbar pain radiating to both thighs, both legs, and both feet. He also complained of numbness in both thighs, both legs, and both feet. Physical examination documented low blood pressure (95/49), low pulse (53), and "no distress". There was absolutely no physical examination performed on the lumbar spine nor any neurological testing. The diagnoses listed of "radiculopathy, lumbar; tooth ache; and headache" were, therefore, entirely unsubstantiated by any physical examination evidence. The patient's complaints remained identical through the subsequent three months of treatment with Dr. Lewis.

M2-06-1379-01

Page Five

As of the last progress note of 05/09/06, the same pain complaints and same lack of physical examination findings were documented. The patient, by that time, was taking Norco 10 mg. q6h, Elavil, Soma, and Tramadol.

A repeat lumbar MRI on 02/22/06 demonstrated essentially the same findings as previously, with no evidence of disc herniation or compression of the spinal cord or nerve roots at any level. Multiple levels of disc degeneration were noted, as well as facet degeneration.

A chronic pain management evaluation was performed by Positive Health Management on 04/10/06. That evaluation was unsigned, even though Dr. Lewis was listed as part of the treatment team and there was a signature block for his name as the “medical director” of that program. Of interest, the evaluation indicated the patient was taking no current pain medications, even though Dr. Lewis was clearly, at that time, prescribing medications, including Norco 7.5, Elavil, Soma, and Tramadol. The “psychological evaluation”, in fact, was nothing more than a listing of the patient’s subjective complaints. There was no psychological testing performed, nor, for that matter, any documentation of a psychologist or psychiatrist evaluating the patient. A request was then made for 20 sessions of a chronic pain management program. That request was twice reviewed by physician advisors, both of whom denied the request as not being medically reasonable or necessary for treatment of the patient’s work injuries.

Letters of reconsideration and dispute subsequently submitted by Positive Health Management were also reviewed. None of the reasons for denial of the chronic pain management program, however, were addressed in either of the letters from Positive Health Management. In fact, the letters essentially stated regulations regarding allowance for chronic pain management program and restated the same goals that were put forth in the original request. There was, however, no actual discussion or rebuttal of the reasons provided and stated within the letters for the program denials.

A chronic pain management program would not be medical reasonable or necessary unless all appropriate lesser levels of medical treatment have been fully exhausted. Moreover, a chronic pain management program was not medically reasonable or necessary nor likely to provide any significant benefit when the primary problem was more indicative of symptom magnification, factious disorder, and malingering, as appeared to be the case with this patient, than pain due to true physiologic cause. This patient has had no appropriate trials of anti-depressant medication nor of individual psychological therapy. The alleged psychological evaluation performed as part of the entrance evaluation for the chronic pain management program did not, in fact, include any psychological or psychiatric evaluation, nor any psychological testing. Therefore, there was no objective or valid medical evidence to support any psychological or psychiatric diagnosis, nor was there any medical documentation of manifestations of psychological illness or distress. In

M2-06-1379-01

Page Six

fact, the medical documentation was of ongoing subjective complaints despite essentially complete lack of objective evidence of clinically significant objective findings or pathology. Independent evaluation has clearly demonstrated multiple positive Waddell's signs, as well as signs of symptom magnification, non-physiological exam findings, and possible factitious disorder. Objective tests have clearly demonstrated over the last three years lack of clinically significant findings, such as disc herniation, spinal cord compression, spinal stenosis, nerve root compression, or radiculopathy. The diagnosis of lumbar radiculopathy was wholly unsupported, therefore, by the entirety of the medical records. Physical examinations consistently revealed no evidence of radiculopathy nor for that matter any medical evidence of physical distress such as elevated blood pressure, heart rate, or respiratory rate.

Therefore, for all the reasons discussed above, based on the entirety of the medical records, there was no medical reason or necessity for twenty sessions of a chronic pain management program as related to the original work injury of this patient dated ____.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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

M2-06-1379-01

Page Seven

Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the patient via facsimile or U.S. Postal Service this day of 06/21/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel