

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

20 sessions of CPMP

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The physician providing this review is a physiatrist. The reviewer is national board certified in physical medicine rehabilitation as well as pain medicine. The reviewer is a member of The American Academy of Physical Medicine and Rehabilitation, International Spinal Intervention Society, American Society for Intervention Pain Physicians. The reviewer has been in active practice for 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical records reviewed does not support the medical necessity of a chronic pain management program

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Healthcare

- Office notes (07/11/05 - 06/18/07)
- Diagnostics (08/25/05 – 06/18/07)
- Operative report (03/17/06)
- Utilization reviews (07/10/07 & 07/23/07)

Insurance Company

- Office notes (07/11/05 - 06/18/07)
- Diagnostics (08/11/05 – 06/18/07)
- Therapy/WHP (08/01/05 - 05/03/07)
- Operative report (03/17/06)
- Medical reviews (09/09/05 – 05/23/07)

Insurance

- Diagnostics (08/25/05 - 11/10/05)
- Operative note (03/17/06)
- Office notes (05/31/07 – 06/18/07)
- Pre-authorization requests (07/02/07 – 07/17/07)
- Utilization reviews (07/23/07)
- PPE (06/18/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was attempting to unroll a tarp when he slipped and fell injuring his left ankle, leg, and knee.

Following the injury, the patient was evaluated at an emergency room (ER), diagnosed with ankle sprain, and treated with an Ace wrap and Motrin. Later, he underwent chiropractic therapy with, D.C.

Magnetic resonance imaging (MRI) of the left ankle revealed degenerative joint disease (DJD) of the talonavicular, medial cuneiform, and first metatarsal joint space. In August, M.D., evaluated the patient for electrodiagnostic examination, which revealed slightly prolonged distal motor latency of the left peroneal nerve at the ankle consistent with mild left anterior tarsal tunnel syndrome.

In a required medical examination (RME), , M.D., assessed left ankle sprain/strain and symptom magnification. He opined that the treatment should have included therapy for one to two weeks and anti-inflammatory medications for up to two to four weeks; tarsal tunnel syndrome would be an ordinary disease of life; there was no indication for ongoing narcotic analgesics; and the patient was capable of returning to light duty offered by the employer.

In a behavioral evaluation, the patient was diagnosed with acute adjustment disorder with mixed anxiety and depressed mood. The evaluator recommended six weeks of low-level individual psychotherapy, which was denied by the carrier.

In a peer review, , D.C., opined that one to two weeks of chiropractic therapy would have been sufficient to resolve the ankle sprain. , M.D., an orthopedic surgeon, prescribed a walker boot and Mobic and felt that the patient might require mid-foot fusion. In a peer review, , M.D., opined that electrodiagnostic studies were not necessary for the diagnosis of ankle sprain and the findings of this study were not valid as related to his compensable injury.

, M.D., assessed left ankle internal derangement syndrome and prescribed Celebrex and Ultracet. He recommended injections in the left ankle and left first cuneiform-metatarsal joint.

Magnetic resonance imaging (MRI) of the left ankle revealed: (1) Cystic degenerative change involving the talus. (2) Tenosynovitis involving the posterior tibial tendon and flexor digitorum longus tendon. (3) Mild tendonitis of

the distal Achilles tendon. (4) Soft tissue edema. (5) Sclerotic density involving the anterior aspect of the talus most consistent with a bone island.

MRI of the left tibia-fibula revealed: (1) Focal area of abnormal signal in the proximal tibia having appearance of either cystic changes or microfractures. (2) Abnormal hyperintense signal in the distal region of the distal tibia and fibula in the region of the ankle. MRI of the right tibia-fibula revealed: (1) Abnormal signal involving the subcortical region of the marrow to mid distal tibia. (2) Overlying soft tissue swelling and irregularity of superficial soft tissue representing a defect or ulceration. MRI of the right ankle revealed: (1) Mild degree of abnormal signal in the distal Achilles tendon. (2) Cystic degenerative change of the talus. (3) Mild soft tissue swelling. (4) Minimal fluid around the joint.

, D.P.M., a designated doctor, opined that the patient was not at maximum medical improvement (MMI). She recommended referral to an orthopedist or a podiatrist (unless done otherwise), oral nonsteroidal anti-inflammatory drugs (NSAIDs), return to light duty, and home exercise program (HEP). She opined that further chiropractic therapy was not necessary. In a medical dispute resolution by independent review organization (IRO), adverse determination against psychotherapy was upheld. , D.P.M., assessed tarsal tunnel syndrome, deep peroneal nerve incarceration/neuritis, and lateral ankle sprain. He recommended surgery.

On March 17, 2006, Dr. performed left posterior tarsal tunnel release, deep peroneal tarsal release anteriorly, and modified Broström lateral ankle stabilization. Postoperatively, the patient developed ulceration secondary to dehiscence. The patient was also suffering from diabetic neuropathy. Wound care in the form of debridement of the hypertrophic skin and application of ointment was performed. By the end of July, the ulcer healed completely and the patient was walking without pain.

In an RME, Dr. rendered the following opinions: Physical therapy (PT) would be appropriate from a licensed therapist. Anti-inflammatory medications for up to six months postoperatively would be reasonable. Ultram or Ultracet would be reasonable for up to three to four months postoperatively. Care beyond September, as well as surgical intervention was completely irrelevant to the work injury. The effects of the injury had long been resolved. He should have been placed at MMI in September. There were no indications for further diagnostics or surgery.

In August 2006, Dr. opined that the patient was not at MMI. She recommended four to six weeks of PT, progressing to work hardening, NSAIDs, and custom-molded orthotics. In a psychological evaluation, the evaluator felt that the patient was coping and adjusting with his injury and related stressors. No treatment was suggested.

Dr. assessed clinical MMI as of January 6, 2007, and assigned 4% WPI rating.

In a functional capacity evaluation (FCE), the patient qualified at a less than sedentary physical demand level (PDL) against his medium job PDL. He

attended four weeks of work hardening program (WHP). Follow-up FCE qualified the patient at the light-medium PDL. The evaluator felt that the patient would never be able to reach the job PDL and might require a more extensive program to aid in a successful return to some type of employment and return to more financial way of life. A chronic pain management program (CPMP) was recommended. Dr. recommended PT.

In a peer review, , D.O., opined that WHP was not reasonable and necessary. Previous designated doctors had recommended return to full duty work. Even after completion of 20 days of WHP, the patient had not progressed to medium PDL. Given his age, it was unclear as to whether or not he had a job to return to.

In May 2007, Dr. noted that the patient was worse despite the surgery. His current pain level, depression, and anxiety level was 7/10. Dr. added Neurontin, Lexapro, Vicodin, and Celebrex.

In a physical performance evaluation (PPE), the patient qualified at the light-medium PDL. The evaluator recommended a CPMP. In a psychological evaluation, the patient was diagnosed with major depressive disorder, pain disorder, and anxiety disorder. The evaluator recommended 20 sessions of CPMP as the patient was not progressing physically and the pain had been refractory to conservative measures. He recommended immediate referral for psychotropic medication consultation.

A request for the CPMP was denied. Rationale: *The patient had three ankle surgeries, physical therapy (PT), injections, and work hardening program (WHP). The pain has increased from 2/10 in December 2006, to 8/10 in June 2007. In January 2007, a designated doctor noted that the patient had pain at 1-2/10. He had assessed maximum medical improvement (MMI) and recommended return to full duty. The request for the CPMP was not warranted as medically necessary.*

On July 23, 2007, appeal for reconsideration of CPMP was denied. Rationale: *past medical history was significant for diabetes. The patient was taking Celebrex currently. He was released to full duty in January 2007, with 4% whole person impairment (WPI) rating. A peer review indicated that the patient had made adequate progress postoperatively. The patient was 73 years old who had already completed a full WHP with good gains according to the doctor. He was in a trucking job and required PDL was medium. He had some chronic pain due to his ankle surgery, but had been released to work and only took one Vicodin a day and Neurontin. He did not have a narcotic problem. The main issue was high levels of anxiety and depression. He was not in counseling, not seeing a psychiatrist, and not on anti-anxiety or antidepressant medications. It was not realistic that the patient could return to work at his prior job. He needed lower levels of care for treatment for his psychological problems. Records did not reflect convincing clinical evidence that the patient would respond to CPMP.*

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

The information reviewed again indicates ongoing pain despite reasonable attempts at treatment at the primary, secondary and tertiary levels of care. The patient has already been declared at MMI indicating a clinical plateau overall and no further material recovery can be expected despite further intervention. The patient has been through work hardening. The patient has already been released at a restricted level of care. There is mixed evidence based literature supporting pain management programs. The emphasis should be on return to work based on restrictions already provided after last work hardening program. The patient does not appear to require detoxification and has ongoing pain management through current medications and antidepressive medications already. There's no indication for a comprehensive pain management program at this point in time based on spine treatment guidelines and previous medical record reviewed.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES