

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

DATE OF REVIEW: AUGUST 30, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten sessions of chronic behavioral pain management program

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

The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation does not support the medical necessity of ten sessions of a chronic behavioral pain management program

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Healthcare:

- Clinic notes (06/12/06 – 06/18/07)
- Therapy notes (PT/CPMP) (06/21/06 – 06/13/07)
- Physical performance evaluation (01/23/07)
- Reviews (07/24/07)

LLC:

- Clinic notes (09/13/06 – 06/14/07)
- Therapy notes (PT/CPMP) (02/12/07 – 06/13/07)
- Physical performance evaluation (01/23/07)
- Reviews (07/05/07 – 07/24/07)
- IRO review (05/17/07)
- Utilization reviews (06/22/07 – 07/10/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was injured when he tripped down some concrete steps and landed in a split fashion with the left leg up and the right leg down the stairs.

In June 2006, D.C. evaluated the patient and noted: *Following the injury, the patient had been treated at an ER where x-rays had shown a possible fracture of the ankle. He then underwent therapy without the x-rays being reviewed and failed to improve. On January 18, 2006, a surgery was performed and a dead bone fragment was removed.* Dr. diagnosed post-surgical bimalleolar fracture, neuritis/neuralgia, and left ankle sprain/strain. PT was started. D.O., prescribed Ultram and later replaced it with Naprosyn. A psychological evaluation was performed, in which a review of x-rays showed a fragment in the posterior ankle joint whereas MRI and CT revealed a nondisplaced vertical fracture. The psychologist assessed chronic pain disorder and recommended individual counseling. The patient returned to Dr. who recommended psychotherapy, which was eventually denied.

A PPE performed in 2007, recommended a comprehensive, multidisciplinary return-to-work program such as chronic behavioral pain management. Meanwhile, PT was continued from January through May. M.D., noted that the patient had undergone an ORIF earlier. Diagnoses included left ankle enthesopathy status post ORIF of left ankle fracture. Naprosyn and hydrocodone were continued. In May, following an IRO review, the patient underwent 10 sessions of a chronic pain management program. On June 5, 2006, M.D., assessed clinical maximum medical improvement (MMI) and assigned 5% whole person impairment (WPI) rating. On June 12, 2007, upon the completion of the CPMP, Dr. recommended additional 10 sessions of CPMP. The diagnosis included left ankle subtalar enthesopathy and left ankle tenosynovitis (anterior extensor tibialis tendon and Achilles tendon status post left ankle ORIF). Ongoing medications were alprazolam, Seroquel, and Ambien CR.

A request for additional CPMP was denied with the following rationale: *The patient was provided a prescription for Seroquel, but no diagnostic impressions were provided. A DDE in June 2006, stated that there was "no further need for any medical treatment, therapy, or surgery" and indicated that the patient was at MMI. Information provided in a telephonic review indicated that the antipsychotic medication was interfering with the patient's ability to benefit from the services offered to him. The patient's psychological function had not been adequately assessed and it was unclear if the underlying mental condition was interfering with ability to progress in the program. The prescribing physician was reportedly not "on board" with the CPMP, and the coordination of care was appropriate prior to entrance into the program. Based on documentation and information provided, the request was not reasonable or necessary.*

M.D., a psychiatrist, performed a DDE and diagnosed posttraumatic stress disorder and avoidant versus schizoid personality disorder. He opined that the symptoms of posttraumatic stress disorder were not related to a nondisplaced ankle fracture. No psychiatric diagnosis or conditions would, in reasonable medical probability, extend to be included in the worker's compensation injury.

On July 10, 2007, the denial was held, given the following the rationale: *The patient had completed 10 sessions of CPMP with minimal gain. A treatment update on June 12, 2007, indicated no change in the patient's psychological symptoms (continued to report severe depression and severe anxiety) and minimal changes in pain level and medication usage. A medical examination on June 12, 2007, stated that his functional status had not markedly improved. Treatment goals for additional sessions were not individualized for him. The request for 10 additional sessions of CPMP was not medically reasonable and necessary.*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. PATIENT WITH PREVIOUS SATISFACTORY CRITERIA FOR ENTRY TO PAIN PROGRAM WHO HAS ALREADY COMPLETED 10 SESSIONS WITHOUT ANY DEMONSTRATED SUBSTANTIVE GAIN FROM TREATMENT. THERE IS NO VALID DOCUMENTATION THAT FITS ANY PEER REVIEWED SCIENTIFIC CRITERIA THAT ADDITIONAL SESSIONS WOULD BE USEFUL.

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

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

McGeary DD, Mayer TG, Gatchel RJ. High pain ratings predict treatment failure in chronic occupational musculoskeletal disorders. *J Bone Joint Surg Am.* 2006 Feb;88(2):317-25.

Haldorsen EM, Grasdahl AL, Skouen JS, Risa AE, Kronholm K, Ursin H. Is there a right treatment for a particular patient group? Comparison of ordinary treatment, light multidisciplinary treatment, and extensive multidisciplinary treatment for long-term sick-listed employees with musculoskeletal pain. *Pain.* 2002 Jan;95(1-2):49-63.