

# **MATUTECH, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** JULY 5, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic pain management program (CPMP), 20 days/sessions [CPT code 97799-CP].

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Utilization reviews (05/16/07 & 06/07/07)  
Preauthorization requests (05/11/07 & 05/31/07)  
Office notes (08/14/06 – 06/01/07)  
Radiodiagnostics and electrodiagnostic (09/11/06 – 01/26/07)  
Therapy notes and FCE (09/29/06 – 05/02/07)

Treatment Centers:

Office notes (09/22/06 – 05/03/07)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who was hit from behind with a cart which ran over her right leg causing twisting injury to her right ankle and knee.

Following the injury, the patient was evaluated at and diagnosed with right knee contusion, back pain, ankle sprain, and treated with a knee brace and Biofreeze. X-rays revealed some degenerative joint disease (DJD) in the right knee. She

was allowed to work in a modified duty. She underwent a few sessions of physical therapy (PT).

Magnetic resonance imaging (MRI) of the right knee was unremarkable.

M.D., an orthopedic surgeon, assessed internal derangement of the right knee; injected the right knee on two occasions; and prescribed Vicodin, Darvocet-N, and Phenergan. On reviewing x-rays, he noted moderate osteopenia in the right knee and the lumbosacral spine.

D.O., evaluated the patient for right leg, knee, foot, and low back pain. He noted decreased range of motion (ROM) of the lumbar spine, myospasms, and myositis, positive straight leg raise (SLR) test, and decreased deep tendon reflexes (DTR) in the right lower extremity. Dr. assessed lumbar displaced disc, right lower extremity radiculopathy, and intractable pain; and prescribed tramadol and Lyrica. The patient did not improve with this treatment. A behavioral evaluation was conducted, and the patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood. The evaluator recommended individual psychotherapy for six weeks and consultation for psychotropic medications. The patient attended one session of individual psychotherapy, but had worsening of her symptoms. Dr. assessed major depression and posttraumatic stress disorder (PTSD), and discontinued her PT and psychotherapy. Electrodiagnostic studies of the lower extremities were unremarkable.

In 2007, M.D., an orthopedic surgeon, noted positive medial and lateral joint line pain, positive Apley's and McMurray's, and lateral collateral pain with stress in the right knee. There was point tenderness to the lateral aspect of the ankle. X-rays of the right ankle revealed a high arch in the foot with arthritic changes to medial and lateral aspects of the malleolus. Both knees appeared normal on x-rays. Dr. assessed internal derangement and chondromalacia of the right knee, and right ankle sprain; and prescribed Celebrex.

MRI of the right ankle was unremarkable. From February through March, Dr. performed five Hyalgan injections to the right knee. Despite this, the patient continued to suffer from severe pain and was using crutches. Based on the history of pain out of proportion, sensitivity to the skin, and diffuse nature of the problem throughout the right lower extremity, Dr. assessed right lower extremity complex regional pain syndrome (CRPS) and recommended evaluation for a chronic pain management program (CPMP) along with possible stellate ganglion block.

In a functional capacity evaluation (FCE), the patient qualified at a sedentary physical demand level (PDL). The evaluator opined that the patient would benefit from CPMP. Dr. stated that CPMP was medically necessary for the patient and cleared her for the same. He prescribed Theragesic patch. M.S., L.P.C., opined that 20 days of CPMP appeared reasonable and medically necessary for the pain symptoms and related psychological problems of the patient.

On May 16, 2007, Ph.D., gave adverse determination for the request of CPMP. Rationale: *The patient was previously approved for individual psychotherapy, but completed one session. She was also given medications, but self-discontinued them. Functional testing had shown poor effort. It was not established that the patient was a good candidate for CPMP. Based on the available information, the request did not appear reasonable and necessary as per evidence-based guidelines.*

Dr. noted that the patient vehemently refused the CPMP and desired a second opinion with a pain specialist. She was using a walker. There was atrophy of the right thigh and calf muscles and right foot-drop. Dr. recommended discontinuation of CPMP. Dr. requested reconsideration of 20 days of CPMP.

On June 1, 2007, Dr. stated: *The patient became hostile when she was handed over a letter of Unimed Direct about denial of reflex sympathetic dystrophy (RSD). She has refused to sign the letter of doctor/patient relationship severance. She was released from care.*

On June 7, 2007, M.D., gave adverse determination for the request for CPMP. Rationale: *There was no objective evidence of damage/structural harm or injuries identified. MRI and electrodiagnostic studies had been negative. Perpetual program of care was without any evidence that additional care would be of any benefit. There was virtually no change in status with explanation of symptoms/limitations into other body regions.*

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

PATIENT WITH SELF-REPORTED CHRONIC SYMPTOMS WHO APPEARS TO HAVE DEMONSTRATED SYSTEMATIC SELF-DIRECTED BEHAVIORS. COMPLIANCE ISSUES HAVE BEEN DOCUMENTED BY HER PROVIDERS. THERE APPEARS TO BE ONLY SUBJECTIVE INTERPRETATION OF PSYCHOLOGICAL DISORDERS AND A FIRM OBJECTIVE DIAGNOSIS HAS NOT BEEN SUPPORTED BY HER PROVIDERS. THUS, IN LIGHT OF THESE FINDINGS, THE REQUESTED TREATMENT DOES NOT HAVE ANY OBJECTIVE SUPPORTING FACTS IN REVIEW OF THE RECORDS CONTAINED HEREIN

**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**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION) NASS CRITERIA**

Robinson JP, Fulton-Kehoe D, Franklin GM, Wu R. Multidisciplinary pain center outcomes in Washington State Workers' Compensation. *J Occup Environ Med.* 2004 May;46(5):473-8.

Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. *Cochrane Database Syst Rev.* 2003;(2):CD002194.

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, Grasdal 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.