

MATUTECH, INC.

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DATE OF REVIEW: JULY 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Thirty sessions of pain management

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

REVIEW OUTCOME

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

Partially Overturned (Agree in part/Disagree in part) It is reasonable to approve an initial ten sessions, and if significant improvement is noted an additional ten. Thirty is not recommended.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

M.A., L.P.C.:

- Office notes (11/10/03 – 11/18/05)
- Procedure notes (08/06/04)
- Radiodiagnostics (01/23/04 - 08/06/04)

Company:

- Office notes (09/06/06 – 06/06/07)
- PPE (04/26/07)
- Utilization reviews (06/07/07 – 06/18/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who fell about 14 feet off a ladder, and landed on his sacrum.

Treatment details are not available.

In November 2003, D.C., diagnosed lumbar disc injury and radiculitis and referred the patient for chronic pain management (CPM). He noted that the patient had been given 20% impairment rating (IR) earlier.

M.D., noted that a designated doctor had given him 22% whole person impairment (WPI) rating. The patient continued to have chronic pain in his sacral area with radiation of pain through the left buttock area without going past the knees. The patient was on no medications and his pain was uncontrolled. Dr. diagnosed fractured sacrum and discogenic pain versus sacroiliac (SI) pain. He prescribed Naprosyn and Ultram.

In January 2004, x-rays of the lumbar spine showed transitional L5 vertebrae with anomalous articulation of the left side of the sacrum, mild retrolisthesis of L4 on L5, and disc space narrowing at L4-L5 mainly posteriorly. M.D., noted that the patient had suffered a herniated disc for which he had been hospitalized for two days. He diagnosed L5 fracture, instability and segmental spondylosis at L4-L5, pseudoarthrosis at left L5-S1, clinical radiculopathy, and low back pain secondary to the above. Magnetic resonance imaging (MRI) of the lumbar spine showed: (a) disc desiccation at L3-L4 with mild disc bulge; (b) degenerative disc disease (DDD) at L4-L5 with mild circumferential bulging of the disc and a small superimposed broad-based midline disc protrusion with changes suggestive of an annular tear along the posterior disc margin near the midline. D.O., performed an electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities, which was normal. He recommended an epidural steroid injection (ESI) at L4-L5. A lumbar discogram was positive for concordant pain at L4-L5 and non-concordant pain at L5-S1. Post-discogram computerized tomography (CT) showed the dye extending 4-5 mm beyond the expected confines of the disc space at L4-L5 in the posterior central and left paracentral location.

Dr. administered injections to the left SI joint on three occasions. The patient continued to have pain and stiffness in his lower back and was on Vicodin, Ultracet, and Motrin. Due to extensive conservative/nonoperative treatment without significant relief, surgical options were discussed. In September 2006, M.D., evaluated the patient following a lumbar ESI. Apparently, the patient's pain symptoms had improved. Dr. diagnosed lumbar discogenic pain, lumbar radiculopathy, bilateral lumbar facet syndrome, bilateral sacroiliitis, and myofascial pain syndrome. He decided to refer the patient to a surgeon to reevaluate for surgical options versus a chronic pain management program (CPMP). The patient had been noted to be anxious and depressed. In addition, he prescribed Lortab, Neurontin, ibuprofen, Ultram, Nexium, Flexeril, Lexapro, and discontinued Xanax.

M.D., a pain specialist, recommended physical therapy (PT) with reconstructive anesthetic blocks to the lumbar paravertebral nerves.

From January through March 2007, Dr. administered a series of three reconstructive anesthetic blocks. In mid March, M.A., L.P.C., evaluated the patient and diagnosed pain disorder and chronic pain with sleep disturbance, depressive symptoms, and anxiety, and ineffective coping skills to manage the

injury-related stress and pain. She advised participation in a multidisciplinary CPMP.

A physical performance evaluation (PPE) placed the patient at the light-medium physical demand level (PDL), which was felt not sufficient for the patient to return to his job. The recommendations consisted of PT, work hardening program (WHP)/work conditioning program (WCP), and CPMP. In June, M.D., evaluated the patient, diagnosed L4-L5 hypermobility, L4-L5 posterior annular tears, left L4 through S1 facet pain. He recommended left SI joint injection to rule out the SI joint as the origin of his pain.

On June 7, 2007, request for CPMP was denied stating that: *clinical findings did not appear or support the medical necessity of CPMP.* On June 18, 2007, the appeal was denied stating that: *There was no documentation of low level of behavioral health treatment for management of depressive symptoms (being prescribed Lexapro). It was unclear as to why a functional restoration program such as WCP had not been considered in lieu of a pain management program.*

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

Recommended where there is access to programs with proven successful outcomes. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy.

ODG:

Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made.
- (2) Previous methods of treating the chronic pain have been unsuccessful.
- (3) The patient has a significant loss of ability to function independently resulting from the chronic pain.
- (3) The patient is not a candidate where surgery would clearly be warranted.
- (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES