



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: April 18, 2008

IRO Case #:

**Description of the services in dispute:**

Chronic pain management (12 session) CPT #97799

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The Psychologist who performed this review is licensed in Psychology by the state of Texas. This reviewer is a Diplomate of the American College of Forensic Examiners. They also hold a master certification in Neuro Linguistic Programming. The reviewer provides services for both adult and pediatric patients within their practice. The reviewer has been in active practice since 1976.

**Review Outcome**

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

Upheld.

The chronic pain management program for 12 sessions with CPT #97999 is not medically necessary.

**Information provided to the IRO for review**

Records Received from the State:

Request for IRO

Initial review by Dr. 2/28/08

Reconsideration review by Dr. 3/17/08

Records Received from the Provider:

Letter of appeal 4/7/08

Referral for treatment 12/13/06  
Treatment plan, unknown date  
Behavioral Assessment 2/8/07  
Discharge Summary 12/20/07  
Functional Capacity evaluation 1/30/08  
Follow up office visit with Dr. 2/28/08  
Request for reconsideration letter 3/10/08

Records from the Insurance Carrier:

Misc case notes from carrier 2/25/08–3/17/08  
Request for Multi disciplinary pain management program 2/21/08  
Required Medical Examination By Dr. 5/9/07

### **Patient clinical history [summary]**

The patient is a female who sustained injuries. She reports she stepped out of an elevator and slipped on marble flooring causing her to fall forward with her right arm outstretched to break her fall. She was immediately taken to the hospital, had x-rays completed and was released with medications. Subsequently she received treatment to include medications, passive and active PT modalities and a cortisone injection. The patient also underwent an MRI of the cervical spine and right shoulder. The MRI of the cervical spine noted straightening of the cervical lordosis and multilevel cervical protrusions without focal impingement. The patient then underwent electrodiagnostic studies which noted moderate right and left carpal tunnel syndromes; however, there was no physiologic evidence of cervical radiculopathy or brachioplexopathy. In 11/05 she underwent right shoulder surgery with rotator cuff repair, SLAP lesion repair, and subacromial decompression. There is mention of a subsequent manipulation under anesthesia completed sometime in 2006.

In 5/06 the patient was seen for designated doctor examination and was placed at MMI. Subsequent evaluation in 10/06 again placed the patient at MMI and indicated 15% impairment.

In 2/07 the patient underwent a behavioral assessment. At that time she reported consistent burning in the low back and stabbing pain in the right side of her neck and shoulder. She also reported sleep disruption, limited activity, difficulty with ADL's, inability to relax, increasing stress, and financial strain. Objective measures were used to determine depression and anxiety levels. Depression was noted to be mild and anxiety was severe. MMPI was also completed and was noted to be within normal range but was also indicative of psychological distress, intense feelings of self doubt and low morale. It was also suggested depression and anxiety were a "major problem". MPI and P3 were also completed and noted to be valid interpretations of the patient's clinical picture.

Diagnostic impression was adjustment disorder with mixed anxiety and depressed mood. Recommendation was made for 4 sessions of individual psychotherapy.

Required medical examination completed in 5/07 opined no further treatment to include pain management was needed.

The patient was also reportedly seen for imaging in the interim. Thoracic myelogram done 10/18/07 was essentially unremarkable, and post myelogram CT reported the presence of a right paracentral and somewhat posterolateral disc bulge at T7-8 compressing the anterior aspect of the thecal sac on the right side and some mild flattening of the thoracic cord at this level.

On 12/20/07 the patient was seen for follow up after having completed 8 sessions of individual psychotherapy between 8/07 and 12/07. The patient was noted to be eager and motivated. She also noted despite her reluctance to being on psychotropic medications that she actually made improvement on Zoloft. Overall the patient was somewhat improved but suffered a slight regression due to worry about future treatment and progress. Beck depression and anxiety scores were initially noted to be mild to moderate and at this point were moderate to severe. BDI was 22 and BAI was 27, prior scores were not documented but were noted to be much lower. Recommendation was then made for participation in multi disciplinary care.

A functional capacity evaluation was completed on 1/30/08. Physical demand level was noted to be sedentary. The patients required PDL to safely return to work based on the Dictionary of Occupational Titles for a General Clerk is light. Analysis of the test revealed the findings to be accurate and that the patient gave a full and maximal effort. It was also noted the patient's beck scores were in the mild range for depression. Recommendation was again made for the patient to participate in multi disciplinary care.

A request was made for 12 sessions of pain management on 2/21/08. On 2/27/08 the request was reviewed and denied by Dr. indicating the patient was unable to sustain gains from IPT and as such has a poor predicted outcome with more intensive treatment. It was also noted the MMPI data was not available as part of the review and was unable to be supplied during the peer to peer call. A letter of reconsideration was submitted. There was some concern expressed regarding the patient's regression being a result of her worry about the future. It was stated the patient was actually concerned that she was regressing because she was concerned she was not actually receiving adequate treatment for her issue. The reconsideration letter stated the patient's clinical picture was such that it met The Official Disability Guidelines and a request for appeal was filed. The appeal was reviewed and denied on 3/17/08 by Dr. He agreed with the initial review in that services would not be appropriate given the patients inability to sustain gains and actually worsen in the IPT sessions. It was also noted there was no explanation for recent non compliance by the patient in that she

failed to show for a RME scheduled on 2/29/08. Dr. also referred to the prior RME in 5/07 where the reviewer opined no further treatment; specifically pain management would be needed.

**Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.**

The chronic pain management program for 12 sessions with CPT #97999 is not medically necessary. The patient underwent MMPI that was within normal limits. Other measures completed that were indicative of depression and anxiety were self reported measures and not completely objective. The patient was also unable to sustain gains in lower levels of care. This is a poor predictor that she will sustain gains in more intense multi disciplinary care. Based on the documentation provided, objective and subjective findings this request is not medically necessary.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

Official Disability Guidelines, Return To Work Guidelines (2007 Official Disability Guidelines, 12th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition)