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DATE OF REVIEW: December 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program (97799), 10 days/sessions

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

The physician providing this review is a Psychologist. The reviewer is licensed in Psychology in the State of Texas. The reviewer is a member of the American Psychological Association, and the International Neuropsychological Society. The reviewer has been in active practice for 28 years.

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (10/15/08 – 10/29/08)
- Office notes (07/14/08 – 10/22/08)
- FCE (09/09/08)
- Utilization reviews (10/16/08 – 10/30/08)

- MRI lumbar spine (05/03/07)
- RME (03/24/08)
- Office notes (07/14/08 – 10/22/08)
- FCE (09/09/08)
- Utilization reviews (10/16/08 – 10/30/08)

ODG guidelines are used for denial.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year-old male who injured his lower back while lifting a tile of boxes on xx/xx/xx.

In May 2007, magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) T11-T12: A small right paracentral disc protrusion measuring 3 mm in AP dimension. (2) L4-L5: A mild disc bulge and bilateral facet and ligamentum flavum hypertrophy.

The patient was treated at Medical Centers and was diagnosed with moderate lumbar, sacroiliac (SI), and thoracic strain. Later, he came under the care of, D.C., who had been treating him with adjustments two to three times a week. A pain specialist diagnosed thoracic and lumbar strain/sprain and facet syndrome and recommended conservative treatment. The patient was placed by Dr. at maximum medical improvement (MMI) with 5% whole person impairment (WPI) rating.

In March 2008, M.D., performed a required medical examination (RME). He noted the patient had complaints of low back pain rated at 6/10 and pain radiating to the left testicle. Currently, the patient was on a home exercise program (HEP) and was on no medications. Examination showed generalized tenderness throughout the lower lumbar area, right more than left, and tenderness over the buttocks, trochanters, and sciatic notch. Straight leg raising (SLR) test caused pain in the low back bilaterally. Waddell's signs were positive x5. Dr. diagnosed chronic low back pain with somatization and deconditioning. He rendered the following opinions: (1) There was no indication for continued structured treatment. The patient should aggressively continue with a self-directed exercise program to include stretching, strengthening, and endurance exercises. Over-the-counter (OTC) medications such as acetaminophen or ibuprofen would be reasonable. (2) The patient had reached a medical endpoint to treatment. He had a lumbar strain and exhibited significant somatization.

In July, Dr. referred the patient for chronic pain management program (CPMP).

On July 24, 2008, Ph.D., noted: *The patient underwent lumbar facet injections in June 2007. In a functional capacity evaluation (FCE) in April 2008, he qualified at a light physical demand level (PDL). He attended 10 days of work conditioning program (WCP).* Dr. noted symptoms consistent with depression and anxiety. Beck Depression Inventory-II (BDI-II) and Beck Anxiety Inventory (BAI) scores were 27 and 22 respectively reflecting moderate depression and anxiety. Dr. assessed moderate major depressive disorder and anxiety disorder and recommended medication consultation, evaluation for psychotropic medication needs, as well as six sessions of individual psychotherapy and biofeedback training.

In September, D.O., assessed chronic low back pain and opined that the patient was a good candidate for CPMP.

The patient attended an FCE and qualified at the light/medium PDL versus heavy PDL required by his job.

On October 10, 2008, Dr. requested CPMP for the diagnosis of pain disorder. Rationale: (1) *The patient reports persistent pain consistent with or out of proportion to physical findings.* (2) *He exhibits overt verbal and nonverbal pain behaviors.* (3) *He demonstrates progressive deterioration in ability to function at home, socially, and at work.* (4) *He reports failure of primary and secondary*

treatment alternatives. (5) He relies on, uses more healthcare services, and/or increases tolerance to drugs. (6) He demonstrates mood disturbance and other indicators of psychological, behavioral, or social distress related to pain and functional limitations. Dr. stated the patient's problems were consistent with the diagnosis of chronic pain syndrome as outlined by the American Medical Association (AMA), the American Academy of Pain Management (AAPM), American Academy of Physical Medicine and Rehabilitation (AAPMR), the chronic pain literature, and the standards of practice in the chronic pain treatment community.

On October 15, 2008, Ph.D., denied the request for CPMP with the following rationale: "The clinical indication and necessity of this procedure could not be established. The behavioral medicine evaluation of July 24, 2008, finds impressions of major depressive disorder and anxiety disorder. However, the treatment request dated October 10, 2008, indicates a diagnosis of pain disorder. But there are no additional clinical or psychometric data in the current request to enable this change. The patient, in fact, independent in all activities of daily living (ADL), is not using any medications, and there is no appropriate psychometric testing to clarify the diagnosis or depict the nature of the patient's distress or whether a chronic pain syndrome is manifest. Such assessment is the standard of care, as provided in the professional literature and ODG guidelines in this regard. In summary, the request is inconsistent with the adequate and thorough evaluation required for admission to a chronic pain rehabilitation program. In addition, the patient is quite overweight, though he has recently lost 12 lbs, down to 275 lbs. Even the lack of indications for a CPMP, weight loss may appear to have some benefit here, although there has been no formal program or concerted effort made. Weight is clearly associated with co-morbid disability, depression, reduced quality of life, and physical function in this type of chronic pain condition; yet there is no allusion to pursuing this on any diligent clinical basis."

On October 22, 2008, M.S., L.P.C., from Texas Health, responded as: "An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement. The patient reports pain and functional problems have not resolved with treatment and that persistent pain markedly interferes with his performance of engagement in activities across broad domains of functioning since his work injury. Surgery has been ruled out. He has repeatedly reported his desire to make full use of services offered in our pain program to achieve treatment objectives needed to prepare him for a safe, successful, and lasting return to work and resumption of other activities important to him. Negative predictors of success have been addressed. He does not smoke or drink. Assessments gathered by the clinical psychologist, , Ph.D., indicated that the diagnosis should be formally changed to that of pain disorder. The patient is not independent in all ADLs. While his pain level is high (8/10 with strenuous activity), and distress significant, they do not pose insurmountable barriers to his participation in this program. ODG does not indicate that obesity is an exclusionary criterion for participation in a CPMP. Thus patient's presenting problems are consistent with the diagnosis of chronic pain program."

On October 30, 2008, Psy.D., denied the appeal for CPMP with the following rationale: "Documentation indicates the patient has been treated with

conservative care, diagnostic testing, injections, and medications. The patient is currently reporting pain at 8/10, moderate symptoms of anxiety (BAI 22, and moderate symptoms of depression (BDI 27). The history and physical indicates the patient is a smoker. The appeal documentation states he does not smoke or drink. Appeal documentation indicates the diagnostic impression has been changed to pain disorder. The appeal request repeatedly states that the patient has exhausted all attempts at conservative care and that an adequate and thorough evaluation has been made. The appeal request specifically takes issues with weight loss as an attempt at conservative care. However, the documentation provided with the request presents with patient's 12-lb weight loss as an attempt at compliance with treatment recommendations. The issue that an adequate and thorough evaluation has not been made was raised in the initial review of this request and has not been sufficiently addressed in the appeal of the request. Multiple negative predictors are present and minimal assessment is provided. Based on documentation and information provided, this request for 10 sessions of CPMP does not meet guidelines and is not reasonable."

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

THE CLAIMANT MEETS THE ODG CRITERIA FOR PARTICIPATION IN A CHRONIC PAIN MANAGEMENT PROGRAM. THESE CRITERIA HAVE BEEN NOTED IN BOTH THE REQUEST FOR SERVICES AND IN THE DENIALS. THE BASIS OF THE DENIAL, PRIMARILY THAT A THOROUGH EVALUATION HAS NOT BEEN MADE IS NOT SUPPORTED. THE EVALUATION RESULTS PROVIDED MEET THE STANDARD OF CARE IN ASSESSING SUITABILITY FOR A CHRONIC PAIN MANAGEMENT PROGRAM. THOUGH THE MMPI-2 IS CONSIDERED TO BE AN EXCELLENT TEST FOR THIS ASSESSMENT IT IS NOT REQUIRED BY ANY OF THE GUIDELINES. THE EVALUATION WAS THOROUGH AND PROVIDED SUFFICIENT DATA TO DETERMINE THE CLAIMANT'S SUITABILITY FOR THIS TREATMENT.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES