

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: July 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program x 10 sessions (97799)

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 chronic pain management program x 10 sessions (97799)

ODG criteria have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who injured his right knee on xx/xx/xx, while lifting and bending down .

PRE-INJURY RECORDS: From 2002 through 2006, the patient was evaluated for elevated bilirubin levels; was diagnosed with Gilbert's syndrome and fatty liver; and was advised on diet, exercises, weight loss, and reduction of alcohol intake. In xx/xxxx, he injured his neck in a motor vehicle accident (MVA). Magnetic resonance imaging (MRI) of the cervical spine revealed degenerative changes from C3-C4 through C5-C6. He was placed in physical therapy (PT). A microadenoma of the pituitary was suspected and was ruled out on further investigations. In xx/xxxx, he twisted his right ankle, was diagnosed with sprain, and was treated with brace/crutches and medications.

POST-INJURY RECORDS

2006: Following the injury, a video surveillance was conducted. The patient was

found to be sweeping the garage with a broom, bending over, and walking around. He appeared to move in an unrestricted manner and wore no visible braces.

MRI of the right knee revealed: (1) Moderate joint effusion. (2) Mild tricompartmental degenerative marginal spurring. (3) 0.7 x 1.6 cm lobulated cyst along with posterior aspect of the lateral tibial plateau within the soft tissue consistent with a small ganglion or a synovial cyst. (4) Complex tear involving the posterior horn of the medial meniscus extending to involve both the superior and inferior articular surfaces. (5) Swelling and edema within the subcutaneous tissues over the anterior aspect. (6) Slight lateral subluxation of the patella with knee extended and measuring 4 mm.

Per DWC PLN 1 report, the patient's claim was denied as the available witnesses did not affirm the alleged injury.

2007: The patient underwent 12 sessions of chiropractic therapy. , M.D., prescribed Lortab and Restoril.

In early March, the patient was admitted with complaints of headaches, dizziness, and truncal ataxia. MRA, MRI, and computerized tomography (CT) of the head revealed a 1.3 x 1.4 cm intraparenchymal hemorrhage within the cerebellar vermis with slight amount of surrounding edema. , M.D., performed suboccipital craniotomy for biopsy resection of hemorrhagic vermion intracerebral mass using microdissection followed by duraplasty with bovine pericardial graft. The patient did well after the surgery and was released to work on April 16, 2007.

Per DWC PLN 11, the carrier disputes degenerative conditions, cysts, spurring, chondromalacia, and/or arthritis of the right knee as well as major depressive disorder as pre-existing and ordinary disease of life.

, M.A., L.P.C., evaluated the patient status post right knee surgery on September 17, 2007, and was on Lunesta and hydrocodone/APAP. She diagnosed moderate major depressive disorder secondary to the work injury and recommended six sessions of individual psychotherapy and biofeedback training. In a functional capacity evaluation (FCE), the patient qualified at a light-to-light/medium physical demand level (PDL) which did not match his job PDL. He attended three sessions of PT.

2008: From January through February, the patient attended 14 sessions of work hardening program (WHP). In an FCE, his current PDL matched with the job PDL and he was felt to be capable of return to work.

, M.D., assessed chronic right knee strain, chronic right ankle pain, and unresolved right knee anterior ligament strain and nodule formation. He prescribed hydrocodone/APAP, Lidoderm patch, and Lexapro, and recommended continuing therapy. In an FCE, it was stated that the patient had shown predictable improvement in function throughout the rehabilitative process; however, his subjective complaints of pain had remained static or even increased. It was suggested that he could benefit from a chronic pain management program (CPMP).

On April 16, 2008, , M.D., a designated doctor, placed the patient at clinical maximum medical improvement (MMI) with 0% whole person impairment (WPI)

rating. The patient was released to regular duty without restrictions. In a rebuttal letter, Dr. stated that the WPI rating should be 1%.

In subsequent FCEs, the patient qualified at the light/medium PDL against the medium PDL required by his job.

Ms. requested 10 sessions of CPMP with the following rationale: *“Prior modalities have failed to stabilize the patient’s psychological distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. He endorses his pain as chronic and persistent ranging from 3-6 x 10 depending on his activity level. He is currently experiencing increased pain and mood symptoms. Surgical intervention has failed to extinguish his pain or increased functioning such that he could make a successful return to work. He had experienced a strong motivation to return to work, control his pain, and move toward case closure. He is very close to reaching his job demand level. He has developed a chronic pain syndrome and the treatment of choice is participation in CPMP.”*

On May 15, 2008, , M.D., nonauthorized the request for CPMP with the following rationale: *“Of note, the claimant had surgery for a brain aneurysm in March 2007, which delayed the rehabilitation of his knee. It is not clearly demonstrated that the claimant has a significant loss of ability to function independently due to his chronic pain. The negative predictors of success have not been addressed as specifically related to prereferral disability time, prevalence of opioid use, and high levels of psychological distress. Based on the clinical information submitted for this review and using the evidenced-based peer reviewed guidelines, the request is not indicated.”*

On June 5, 2008, , Ph.D., nonauthorized the request for reconsideration of CPMP with the following rationale: *“I discussed the case with Dr. . The patient is near his desired PDL level currently, has rather limited psychological stressors that are preventing his ability to return to work, and the psychological problems listed are likely more related to his previous cerebral hemorrhage and cerebral aneurysm repair. Unfortunately, depression and memory loss are common consequences for those that actually do survive cerebral aneurysm ruptures and undergo surgical interventions to repair those aneurysms. The goals of the program are to reduce pain, increase his stamina and reduce medication usage. Pain reduction is not necessarily a goal of chronic pain program and the patient does not now have debilitating pain. The other goals do not require a chronic pain program to accomplish them. As such, the current request is not medically necessary.”*

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

Patient with history of liver dysfunction in whom most treatments have not worked effectively.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

Gallagher RM. Treatment planning in pain medicine. **Integrating medical, physical, and behavioral therapies.** *Medical Clinics of North America*. 01-May-1999; 83(3): 823-49, viii.

Guzman J, Esmail R, Karjalainen K. et al. **Multidisciplinary Rehabilitation** for Chronic Low Back Pain: Systematic Review. *BMJ* 2001;322:1511-1516.