

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: May 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program (97799) x 20 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 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

Texas Department of Insurance

- Utilization reviews (03/24/08 – 04/16/08)

Company

- Office notes (10/27/06 - 04/07/08)
- FCE (03/06/08)
- Utilization reviews (03/24/08 – 04/16/08)

Centers

- Office notes (10/27/06 – 04/07/08)
- Review by IRO (12/17/07)
- Utilization reviews (03/24/08 – 04/16/08)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured. He was charging a forklift battery. When he plugged it into the charger, the charger shorted and shocked the patient. He was knocked onto the cage rail and injured his back and right arm.

In October 2006, M.Ed., L.P.C., evaluated the patient on referral of D.O. *After the injury, the patient sought initial medical treatment at an emergency room (ER) where x-rays were done and pain medications were prescribed. Later, he received more pain medications, physical therapy (PT), and was placed on light duty work.* Current medications were Vicodin and Flexeril. Current complaints were numbness and tingling in his right arm and right leg. History was significant for knee arthroscopic surgery and right ankle fracture. The patient reported that his level of overall functioning prior to the injury was 100% and his current level was 55%. The patient scored 17 on a Beck Depression Inventory II (BDI) and 16 on the Beck Anxiety Inventory (BAI) indicative of mild depression and moderate anxiety. He was diagnosed with adjustment disorder with mixed anxiety and depressed mood directly related to the work injury. Other diagnoses were displacement of cervical intervertebral disc without myelopathy and lumbosacral spondylosis without myelopathy. He was recommended participation in a low-level individual psychotherapy for a minimum of six weeks.

In December 2007, the patient underwent a review by an independent review organization (IRO) for the disputed services of laminectomy and fusion at L4-L5 and L5-S1. *Lumbar myelogram/computerized tomography (CT) in May 2007, revealed advanced disc degeneration at L5-S1 with a disc herniation. Lumbar discogram/CT in July 2007 revealed disruption and severe concordant pain at L4-L5 and L5-S1. The patient was cleared psychologically for this surgery. A lumbar discogram in September 2007 was normal at L3-L4. recommended laminectomy and fusion at L4-L5 and L5-S1.* The reviewer upheld the previous adverse determinations. Rationale: *In short, this patient does not meet the criteria for lumbar laminectomy and fusion. The pain generators are unclear. The compounding psychological issues have not been addressed. There is no clearcut diagnosis other than discogenic pain, which in this population responds poorly to surgery. Therefore, the requested laminectomy and fusion at L4-L5 and L5-S1 is not reasonable or necessary.*

In February 2008, Dr. evaluated the patient for right arm pain and low back pain. Ongoing medications were diazepam, hydrocodone, prednisone, Flexeril and Nexium. Examination revealed decreased range of motion (ROM) in the right hand and dysesthesia and neuralgia of the right hand secondary to electrical injury. Examination of the lumbar spine revealed paravertebral spasms and tenderness. There was a 4 x 4 cm hematoma across the lumbar and sacroiliac (SI) region extending down into the right proximal buttock. Straight leg raise (SLR) test was positive on the right with decreased deep tendon reflexes in the right lower extremity. Dr. diagnosed lumbar displaced disc at L5-S1, disc disruption syndrome at L4-L5 and L5-S1, right lumbar radiculopathy, disc space narrowing at L4-L5 and L5-S1, cervical displaced disc, cervical radiculopathy in the right arm, electrical burn with intractable pain, and sleep disturbance/anxiety/depression secondary and causally related to the work injury. He prescribed Darvocet-N, Flexeril, and Lyrica and stated that chronic pain management program (CPMP) was medically necessary for the patient.

The patient underwent a functional capacity evaluation (FCE). *Magnetic resonance imaging (MRI) of the lumbar spine in November 2006 revealed degenerative disc disease (DDD) at L5-S1 including disc bulge with left paracentral disc protrusion components and DDD at L4-L5 with some mild generalized disc bulge. Electromyography/nerve conduction velocity (EMG/NCV) in December 2006 was normal. The patient underwent lumbar epidural steroid injections (ESIs) x4 from February through April 2007. The patient qualified at a medium-heavy physical demand level (PDL) and it was felt that he might benefit from CPMP. At the end of the FCE, he had elevated blood pressure and was referred to his family doctor for that.*

On March 10, 2008, M.S., L.P.C., noted the patient had completed six weeks of individual psychotherapy in late 2006. Mr. opined: *Prior treatment modalities have failed to stabilize patient's psychological distress, increased his engagement and activities of daily living, or enhanced his physical functioning such that he could safely return to work. He is approximately one-and-a-half year status post injury and surgical intervention has been denied. He has developed a chronic pain syndrome and treatment of choice is participation in an interdisciplinary pain rehabilitation program. Authorization for 20 days of CPMP appeared reasonable and medically necessary for any lasting management of his pain symptoms and related psychological problems.*

On March 24, 2008, the request for 20 sessions of CPMP was denied in an initial utilization review. Rationale: *There is no documentation or known finding that the patient's treating physician has exhausted all other appropriate care for this problem, an essential feature of a qualifying diagnostic impression of a chronic pain syndrome and a clinical indication for initiating a pain management program. This is not addressed in Dr. 's history and physical of September 20, 2008. The psychological evaluation of October 27, 2006, (now 17 months old), infers an impression of adjustment disorder, which is not consistent with a chronic pain syndrome or level of disability requiring a chronic pain management program (CPMP). In addition, there are no appropriate psychometric assessments (limited to BAI and BDI) done with this evaluation. Such is usual and customary practice and indicated in evaluating patient's for a CPMP, specifically in supporting the offered diagnoses, ruling out other conditions that may explain the symptoms, more accurately assessing the type of chronic pain presentation, rendering a more accurate prognosis for treatment in the program and designing the unique aspects of treatment for this patient. The BDI is not a valid and helpful measure in this assessment.*

On April 7, 2008, M.A., L.P.C., responded in the following manner: *Dr. does not use the exact words of exhausted all treatment options. He does mention how he has been denied lumbar surgery so he will proceed with a chronic pain program to help him return to work. He has deemed this program as medically necessary in his history and physical note. The intake dated October 27, 2006, only includes BDI and BAI scores. His scores were BDI-II 17, mild depression and BAI of 16 moderate anxiety. The patient was not referred for formal psychometric testing as he did not exhibit symptoms consistent and formal, more costly evaluative measures. Testing would have only delayed the treatment process for this gentleman. He completed 6 sessions of individual therapy back in June 13, 2007. With individual therapy, he made gains in increasing activities*

of daily living and was also communicating better with his family and was feeling less frustrated. Ms. offered diagnosis of chronic pain disorder associated with both psychological factors and a general medical condition related to the work injury. She recommended participation in 20 days of CPMP.

On April 16, 2008, an appeal for the request of CPMP was nonauthorized with the following rationale: *According to Dr. the appeal letter on April 7, 2008, provides an update of the patient's psychological status. However, this is not a comprehensive multidisciplinary evaluation and does not address negative predictors of success, which have been identified for this patient. Without a current and adequate psychological evaluation, the appropriateness of this request cannot be determined. ODG recommend an adequate and thorough evaluation before the appropriateness of a CPMP can be determined. There is no current physical examination by the physician associated with the requesting program. There is no proposed protocol or time contingent schedule for withdraw of narcotic medications. Without the necessary documentation, the necessity of the requested treatment could not be established. Many of the issues raised by the initial reviewer were not adequately addressed in the appeals correspondence, and in my opinion, the appeals correspondence does not impact the prior non-authorization.*

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

Patient had positive discogram and clear pain generators. However, the clinical picture is confounded with psychological abnormalities which now make strategic interventional treatment unclear. In fact, the argument that surgery is a clear choice for resolving pain is in direct conflict with the argument that a pain program is medically necessary. Therefore, the notes do not provide a reasonable support for entry criteria into the pain program and directly contradict the ODG guides.

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

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Gatchel RJ. 2005. Clinical Essentials of Pain Management. Washington, DC: American Psychological Association; 2005.

Stanos S, Houle TT. Multidisciplinary and interdisciplinary management of chronic pain. Phys Med Rehabil Clin N Am. 2006 May;17(2):435-50, vii.

Bendix AF, Bendix T, Labriola M, Boekgaard P. Functional restoration for chronic low back pain. Two-year follow-up of two randomized clinical trials. Spine. 1998 Mar 15;23(6):717-25.