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Notice of Independent Review Decision

DATE OF REVIEW: October 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799: Chronic pain management program (CPMP); 10 daily sessions, 8 hours per day

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 97799: Chronic pain management program (CPMP); 10 daily sessions, 8 hours per day

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (08/18/08 – 09/11/08)
- Office notes (10/08/03 – 08/27/08)
- Diagnostics (10/15/03 – 01/29/08)
- Therapy (10/09/03 – 12/10/07)
- Procedures including injections (02/25/04 – 07/10/07)
- Reviews/RME/DDE (07/29/04 - 05/28/08)
- Utilization reviews (08/18/08 – 09/11/08)
- Office visit (09/12/07 – 08/11/08)

ODG have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who was injured on x/xx/xx. She was handling and lifting material (repetitive activity) when she strained her back and abdomen (internal reproductive organs).

2003: Initially, the patient was seen by , D.C., for pain in the neck, mid back, low back, and abdomen as well as bladder incontinence. She had a history of a lumbar surgery 10 years ago. Dr. diagnosed sprain and strain of the cervical, thoracic, and lumbar spine and recommended physical therapy (PT) and further diagnostics. , M.D., prescribed Ansaid, Darvocet-N, and Soma. X-rays of the cervical spine revealed moderate disc height loss and anterior and posterior osteophyte formation at C4-C5 and C5-C6. X-rays of the thoracic spine revealed mild-to-moderate spondylosis. X-rays of the lumbar spine revealed L5-S1 fusion and mild spondylosis. Electromyography/nerve conduction velocity (EMG/NCV) study revealed acute irritability in the bilateral C7 motor roots. There was insertional activity and radiculopathic changes in the bilateral L5 and S1 motor roots with some lower sacral, S2-S4 lower sacral and S2-S4 involvement. Upper extremity evoked potential study revealed bilateral C7 motor radiculopathy. Evoked potential study of the lower extremities indicated a left L3 and L4 sensory slowing and borderline right L5 sensory slowing as well as bilateral L5 and S1 motor radiculopathy.

Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Mild disc height loss and loss of disc signal with bulges at L2-L3 and L3-L4. (2) Status post fusion at L5-S1 with extensive magnetic susceptibility artifact in the posterior elements limiting the examination. MRI of the pelvis was negative. The patient was continued on therapy.

2004 – 2005: Computerized tomography (CT) of the lumbar spine revealed: (1) Post surgical fusion changes at L5-S1. (2) Mild degenerative changes at sacroiliac (SI) joints. (3) Mild anterolisthesis at L4-L5 with facet hypertrophy, degenerative changes with intraarticular lucency, and mild narrowing of the proximal neural canals.

, M.D., performed cervical epidural steroid injections (ESIs) x2 and a lumbar ESI with not much relief. He tried various medications including Vioxx, Darvocet, Mobic, and Skelaxin. MRI of the cervical spine revealed disc pathology at C4-C5, C5-C6, and C6-C7 levels. In a psychological evaluation, the patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood, chronic pain syndrome, and pain disorder and was recommended individual therapy and medication management.

In a required medical evaluation (RME), , M.D., rendered the following opinions: (1) There was no structural damage to the lumbar or cervical spine. (2) The patient had difficulty carrying out essentials of previous position in the workplace which led to the ongoing medically unnecessary and medically inappropriate treatment. (3) Based on the functional capacity evaluation (FCE), she was capable of returning to a sedentary or light duty. (4) She had a chronic pain

syndrome with dysfunctional pain behavior that had been enable for tertiary gain and led to iatrogenic disability. The patient was seen by a number of physicians including orthopedics, neurologist, and pain management. All of whom recommended further diagnostics. Lumbar myelogram-CT revealed an apparent diffuse disc herniation mainly to the left at L4-L5 with a combination of facet hypertrophy resulting in foraminal stenosis in the left and to some extent on the right. She attended 10 sessions of individual psychotherapy.

, M.D., an orthopedist, felt that the patient was going to require surgical intervention. , M.D., a neurosurgeon, recommended exhausting the conservative treatment prior to any surgery. She had episodes of falling. Dr. felt that she was going to need decompression as the medications were not helping. Dr. noted that the patient underwent surgery on the right ankle after a fall incidence.

Dr. assessed statutory maximum medical improvement (MMI) as of September 7, 2005, and assigned 15% whole person impairment (WPI) rating. He stated if WPI rating was added for the neurogenic bladder, it would be 19% WPI rating.

2006 – 2007: In April 2006, Dr. changed the WPI rating to 28%. He stated the patient was unable to perform any gainful activity. Dr. opined the patient had no neurological condition for lumbar and cervical spine and she should be treated conservatively. , M.D., a neurosurgeon, recommended continuing conservative care for the cervical spine. In an impairment rating review (IRR), , M.D., opined 10% WPI rating would be appropriate for lumbar spine and 5% for the cervical spine.

, M.D., a designated doctor, assigned 10% WPI rating with the statutory MMI.

, M.D., a pain specialist, assessed post lumbar laminectomy syndrome, lumbar radiculopathy, lumbar herniated disc, lumbar facet syndrome, cervical herniated disc, and cervical radiculopathy. He prescribed MS Contin, Norco, and Cymbalta. Dr. assessed neurogenic bladder with urgency, frequency, and urge incontinence and recommended Urodynamic workup. Repeat MRI of the cervical spine revealed posterocentral, left paracentral, and posterolateral disc protrusion with thecal sac impingement at C4-C5; posterior central disc protrusion at C5-C6 and C3-C4 with thecal sac impingement, and posterior central disc bulge at C6-C7. Dr. performed a lumbar ESI and changed medications to Duragesic patch, Norco, amitriptyline, and Zanaflex.

In a designated doctor evaluation (DDE), Dr. rendered the following opinions: (1) The patient was unable to return to work given the combination of neurological problems and medication use. (2) Extent of injury included cervical and lumbar strain. (3) The lower urinary tract symptoms did not represent a neurological problem and were not related to her previous problems in the spine.

The patient attended few sessions of individual psychotherapy in later 2007.

2008: MRI of the lumbar spine revealed as follows: (a) A slightly narrowed disc, mild hypertrophic arthritis of the facets (left more than right) at L2-L3. (b) A slightly narrowed disc with slight diffuse bulge at L3-L4. (c) Mild hypertrophy of the facets with slight thickening of the ligamentum flavum with mild narrowing of

the lateral recess on the left. (d) Slight anterolisthesis at L4-L5. Severe hypertrophy of the facet joints, particularly on the left with only bulky intramedial with osteophytes narrowing the recess, left more than the right. Dr. recommended continuation of pharmaceutical management, individual psychotherapy, electrical muscle stimulation (EMS) unit, and Urodynamic cystoscopy. Dr. refilled Duragesic patches, Norco, amitriptyline, and Zanaflex and recommended a trial of spinal cord stimulation (SCS).

In a DDE, , M.D., opined as follows: (1) The patient's symptoms were certainly more supportive of a stress incontinence rather than incontinence secondary to the injury. (2) Based on the FCE, she had the ability to return to work in a sedentary to light capacity.

In a psychological evaluation, , M.S., L.P.C., stated the patient had received six sessions of individual psychotherapy for depressive and sleep disorder. On the recent FCE, the patient functioned at a sedentary physical demand capacity (PDC) and did not meet the medium PDC requirement of her job. On the Beck Anxiety Inventory (BAI), she scored 15 and on the Beck Depression Inventory (BDI) she scored 13. The sleep questionnaire score was 37. Ms. recommended 10 sessions of chronic pain management program (CPMP).

On August 18, 2008, Ph.D., denied a request for the CPMP sessions with the following rationale: *"On August 15, 2008, at 3:05 pm I left a message for peer-to-peer with . On August 18, 2008, at 9:30 am, I spoke with and reviewed the request. This patient has an extensive treatment history including psychological treatment. She was being considered by her doctor for an SCS trial in 2007, but it is unclear what happened with this as the available medical does not address this issue. Little recent medical available. Most recent notes document patient not showing for appointments and self limiting behavior from evaluation dated May 28, 2008. Need clarification on SCS issue and there are multiple red flags. Based on the available information, the request does not appear to be reasonable or necessary per evidenced-based guidelines of Official Disability Guidelines (ODG) for low back."*

On August 27, 2008, Dr. noted the patient reported high level of pain at her low back area and rated it at 9/10 constantly. There was radiating pain down to her lower extremities bilaterally with the right greater than the left. She had run out of medications and that was affecting her tremendously. She was using a walking cane during ambulation. She reported that the pain was preventing her from carrying out her normal activity of daily living. Dr. assessed cervical herniated nucleus pulposus (HNP), lumbar radiculopathy, cervical pain syndrome, myofascial pain syndrome, and difficulty walking. He referred her to Dr. for pharmaceutical management, referred her to Dr. for orthopedic consultation and recommended CPMP, continued use of EMS unit, off work status, and urodynamic cystoscopy.

On September 3, 2008, Ms. responded to the denial as: *the patient did complete three individual counseling sessions in 2003 and most recently six additional sessions with our facility. She further received psychiatric care from Dr. in 2003. The 9 individual counseling sessions were not an excessive amount of psychological treatment. Further despite having received, extensive treatment as described by the peer review doctor, she continued to experience*

severe elevated levels of pain and other associated psychological stressors. Dr. , on August 27, 2008, documented the patient was reporting a high level of pain at the lower back area. The patient stated the pain was preventing her from carrying out her normal activities of daily living. An FCE, on July 14, 2008, showed she was a good candidate for CPMP.

On September 11, 2008, , M.D., denied the appeal for CPMP with the following rationale: "On September 11, 2008 at 10:20 am, I called for Dr and left a message. At 12:05 pm, I called and spoke with , L.P.C. No drug screen. She could not confirm actual drug use. FCE invalid. No physiologic parameters. Not accurate baseline. No documentation from any provider of discharge attempt at SCS. Significant lapse well over months in evaluation/treatment."

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

Patient with multiple symptoms, reported history of issues with medications and drugs, who has failed multiple attempts at rehabilitation. There is a lack of documented valid "entry criteria" for a chronic pain program especially no positive predictors of success.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES