

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** February 4, 2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program (97799) x10 days/sessions

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

Member of the American Psychological Association  
Member of the International Neuropsychological Society  
Licensed in State of Texas as Psychologist with Health Service Provider Designation  
National Register of Health Service Providers in Psychology

**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**

**Texas Department of Insurance**

Utilization Reviews (11/14/08 – 12/12/08)

**Company**

Office notes (12/04/07 - 10/28/08)

Review (12/02/07)

Diagnostics (12/22/05)

Utilization Reviews (11/14/08 – 12/12/08)

Office notes (12/04/07 - 10/28/08)

Review (12/02/07)

Diagnostics (12/22/05 – 04/20/06)

Utilization Reviews (11/14/08 – 12/12/08)

**ODG criteria have been utilized for the denials.**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who injured his back on xx/xx/xx. While attempting to lift a bucket weighing at least 300 pounds by himself he felt a pop in his back and pain into his left leg.

Magnetic resonance imaging (MRI) of the lumbar spine obtained in December 2005 revealed annular tear with asymmetric annular bulge in the left posterolateral corner of L3-L4 and annular tear with broad-based annular bulge at L4-L5. Electromyography/nerve conduction velocity (EMG/NCV) study performed in 2006 revealed findings consistent with bilateral L5/S1 root irritation with paraspinal activity most consistent with radiculopathy. There was clinical hyperreflexia.

M.D., conducted a medical evaluation in October 2007 and noted the following treatment history: *Following the injury, the patient underwent MRI. He subsequently developed some neck symptoms. M.D., carried out discograms which revealed non-concordant pain at the L5-S1 level, a myelogram that showed no nerve root compressions, but computerized tomography (CT) showed questionable L5 contact the lateral recesses. According to Dr. s note, the patient had absent reflex at the ankle jerks and significant weakness of the plantars and great toe extensors on the left. He was subsequently taken to surgery in April 2007 and a 360-degree fusion was carried out at the L4-L5 and L5-S1 levels. Following the surgery, patient's leg pain switched to the right. A CT scan indicated right S1 pedicle screw possibly compromised the right S1 nerve root. The screw was subsequently removed and replaced by Dr. The patient underwent extensive rehab program postoperatively and was taking Vicodin but recently cut off this and switched to another medication. Dr. assessed status post lumbar strain and development of lumbar radicular syndrome, status post two-level fusion at L4-L5 and L5-S1, status post compromise of right S1 nerve root sleeve from pedicle screw with replacement of that pedicle screw, and failed back surgery syndrome with continued lumbar radicular complaints. He rendered the following opinions: (1) The patient had undergone significant amount of chiropractic care and it was questionable whether further chiropractic care would be beneficial. (2) The patient certainly should be on a home-based program of exercise. Ultimately, four-to-six-weeks program of work hardening might be required. If the patient continued to have significant atrophy in his leg, further diagnostic studies might include repeat myelogram and post-myelogram CT to see if there was evidence of significant nerve root compression. (3) The patient no doubt would require some form of pain medication management and might ultimately require pain management program of a multidisciplinary variety in an attempt to try to wean him off from narcotic medications and into a more functional status from that perspective.*

In his note dated November 9, 2007, Dr. noted the following: *In 2006, the patient underwent caudal an epidural steroid block and physical therapy (PT). Myelogram/CT revealed mobile retrolisthesis of L4 on L5 indicating mild instability; disc bulge measuring 4 mm, lateral recess stenosis impinging the lateral nerve roots, mild bilateral facet joint hypertrophy, and significant central canal stenosis secondary to facet hypertrophy and ligamentum flavum hypertrophy at L4-L5; and breach in the medial wall of the right S1 foramen*

*causing compromise of the right S1 nerve root. Plain films revealed some gaping of the facets at L4-L5. In April 2007, the patient underwent anterior-posterior (AP) fusion from L4-S1 and revision surgery for breached right S1 pedicle screw which immediately resolved the right leg problem and pain problems. In June 2007, myelogram/CT scan revealed breach in the medial wall of the right S1 foramen causing compromise of the right S1 nerve root. MRI obtained in September 2007 revealed decreased signal intensity as well as 1-mm bulge with mild right facet joint hypertrophy at L3-L4. In October 2007, the patient underwent hardware block, following which his pain abated for four days. Dr. opined the patient was a candidate for explantation of his retained symptomatic posterior fixations at L4, L5, and S1 bilaterally.*

The patient had pre-surgical behavior medicine consultation. It was noted that he had been experiencing sexual dysfunction, urinary incontinence, and bowel movement problems in 2006. Also following the myelogram in 2007, the patient developed pain at the puncture site and since then had difficulty lying flat on his back and even breathing at times. He was utilizing Norco a few pills more than was prescribed. The psychologist diagnosed severe major depressive disorder and postlaminectomy syndrome of the lumbar region. It was recommended that the patient be evaluated for psychotropic medications and should receive authorization for three individual psychotherapy sessions.

**2008:** In August, D.C., noted that the patient had hardware removal surgery in February 2008.

D.O., noted that the patient had generalized paravertebral hypertonicity from L1 through the sacrum bilaterally, decreased range of motion (ROM), mild gait disorder with slow walking. He assessed chronic low back pain, bladder dysfunction secondary to chronic low back pain and subsequent surgeries, and major depressive disorder. He recommended chronic pain program and felt that the patient was certainly not a candidate for further surgery. He opined that patient's depression had to be addressed as well as the patient should be given alternatives to medication to help with his pain control.

In a functional capacity evaluation (FCE), the patient qualified at a sedentary physical demand level (PDL) versus very heavy PDL required by his job.

M.S., a psychologist requested authorization for chronic pain management program (CPMP) with the following rationale: *"The prior treatment modalities have failed to stabilize patient's psychosocial distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. The patient is approximately xx years status post injury and has not successfully returned to work. His pain is chronic, persistent, and intractable. Conservative care has been sufficient to extinguish his pain or increase his functional tolerances such that he could successfully return to work. He describes limited functioning within daily, job, and family activities. He has developed chronic pain syndrome and the treatment of choice is participation in an interdisciplinary pain rehabilitation program. The patient's treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce the patient's pain experience, develop self-regulation skills, and facilitate to timely return to unrestricted duty."*

On November 14, 2008, the initial request for chronic pain program was denied by Ph.D., with the following rationale: *“The request is inconsistent with the requirement that there is an absence of other options likely to result in significant clinical improvement” and with “adequate and thorough evaluation” required for admission to a chronic pain rehabilitation program. The patient remains constipated and significantly underweight. There is also still no urological consult and no evidence that the treating physician has formally requested this. Since the impotence and incontinence problems are significant to the patient’s psychological status, a treatment plan (if possible) would need to be generated before a chronic pain program is considered, since such relies heavily on addressing the psychological consequences of the injury to promote functional change. Also, 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 qualifying diagnostic impression of chronic pain syndrome and a clinical indication for initiating a pain management program.”*

Compensability: *At this time, the carrier has accepted the following injury as compensable: Lumbar spine, annular tear and bulge at L4-L5, annular tear and bulge at L3-L4, arthropathy of L4-L5 and L5-S1, and nerve root irritation and radiculopathy at L5-S1. The carrier expressly denies that the injury extends to psychiatric disorders including psychotic features, major depressive disorder, and suicidal tendencies as related to the compensable injury. Carrier expressly denies all other injuries, conditions, diagnoses, and symptoms as not being the result of the compensable injury or the direct and natural result thereof.*

On December 3, 2008, reconsideration request for CPMP was placed with the following rationale: *“It was related to Dr. on a couple of occasions that Dr. could not find a dietitian provider in the Workers’ Compensation Network. With respect to urological consult, it was reported that the urologist had required guarantee of payment. With the absence of this guarantee, the patient has not been seen by the urologist. With regards to exhausting all other appropriate care, the patient has had physiotherapy, injections, and underwent three surgeries. He has also had unimodal individual psychotherapy that had reduced distress and eliminated suicidal ideation and reported auditory hallucinations. It is now xx years and xx month since the patient sustained his work injury and his health, functioning, and lifestyle has been negatively altered by the work injury and treatments provided have not yielded the lasting improvement or fully restored his health and functioning.*

On December 12, 2008, the reconsideration request for CPMP was denied by Ph.D., with the following rationale: *“The patient has a very complicated history and set of symptoms. The patient has a history of suicidal ideation, hallucinatory behavior, chronic medical complications to his injury and previous surgeries, reported severe depression and anxiety, psychosocial stressors, and cultural issues. Yet there is not a full psychological assessment of this patient or a delineation of how all these issues impact his continuing pain and disability. The basis for the psychological recommendation of a CPMP is reported to be the result of a case conference between the clinic’s providers rather than a formal psychological assessment. These various issues do not appear incorporated into the treatment plan as well. The last formal psychological evaluation that was conducted was in December 2007 and only recently have there been Beck*

*Inventories re-administered which are essentially the same as the December 2007 evaluation. Given this, there cannot be determined that a full and thorough assessment has been completed which provides the basis for CPMP.”*

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

THE PROVIDER MET THE ODG RECOMMENDATIONS FOR REFERRAL TO A CHRONIC PAIN MANAGEMENT PROGRAM. AS NOTED IN THE ODG: ODG criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made.
- (2) Previous methods of treating the chronic pain have been unsuccessful.
- (3) The patient has a significant loss of ability to function independently resulting from the chronic pain.
- (3) The patient is not a candidate where surgery would clearly be warranted.
- (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.

The documentation provided appears to meet these guidelines.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**