

# MATUTECH, INC.

PO Box 310069  
New Braunfels, TX 78131  
Phone: 800-929-9078  
Fax: 800-570-9544

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## Notice of Independent Review Decision

**DATE OF REVIEW:** July 6, 2009

**IRO CASE #:**

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

20 sessions of chronic pain management program

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

Board Certified Diplomate of the American Board of Physical Medicine and Rehabilitation

**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 the health care services in dispute.

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx -year-old, who while pulling a trash dumpster with other guys, slipped and hurt his back on xx/xx/xx.

Following the injury, the patient was evaluated at Medical Centers. X-rays of the lumbar spine were unremarkable. He was diagnosed with lumbar strain, was prescribed medications, and was released to modified duty work. From January through April, the patient attended 13 sessions of physical therapy (PT) consisting of electrical stimulation, therapeutic procedure, and hot/cold packs.

On January 20, 2009, D.C., noted complaints of constant burning sensation particularly down into the right lower extremity. He assessed lumbar radiculopathy and recommended to rule out lumbar disc herniation. He recommended progressive rehab program and placed the patient off work.

M.D., a pain management physician, noted tenderness over the paraspinal musculature of the lumbar spine, painful lumbar range of motion (ROM), pain

with bilateral straight leg raise (SLR) test, and decreased sensation in the left L5-S1 distribution. Dr. assessed lumbar strain and prescribed Lorcet, baclofen, Feldene, and Restoril.

Magnetic resonance imaging (MRI) of the lumbar spine demonstrated a broad-based 5-mm disc protrusion at L5-S1 causing mild right lateral recess encroachment as well as mild-to-moderate posterior displacement of the proximal S1 root; mild-to-moderate right facet osteoarthropathy with likely mild right foraminal narrowing; moderate to marked facet osteoarthropathy and mild ligamentous hypertrophy at L4-L5 bilaterally; and 3-mm concentric disc protrusion at L4-L5 causing mild impression upon the ventral thecal sac with mild central and bilateral recess stenosis and marked foraminal encroachment. Electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities showed acute right S1 radiculopathy.

In a mental health evaluation, the patient was diagnosed with pain disorder associated with both psychological factors and general medical condition and major depressive disorder and was recommended 20 days of comprehensive chronic pain management program (CPMP).

On March 23, 2009, Dr. performed selective nerve root block (SNRB) at L5 and S1 bilaterally and noted 50% reduction in pain.

The patient complained of constant pain in his back radiating into both lower extremities and bouts of numbness and tingling in his legs. In view of failed conservative care Dr. recommended surgical intervention.

On May 6, 2009, M.D., conducted a designated doctor evaluation (DDE) and opined the extent of injury included lumbar strain, lumbago, leg pain, paresthesia, and lumbar herniated disc. Lumbar radiculopathy, facet arthritis, and lumbar spondylosis were not included as the extent of injury.

On May 19, 2009, the patient underwent Mental Health Evaluation and was diagnosed to have problems and critical issues including severe level of depression, severe level of anxiety, high levels of pain (10/10), high levels of stress from pain and current disability, significant vocation readjustment required in order to return to work, reliance on pain medication to treat symptoms, ineffective skills or techniques to deal with his pain or stress, and limited adult social support. He was recommended comprehensive 20 days of CPMP that would include individual psychotherapy, group psychotherapy, biofeedback, vocational counseling, exercises, and PT.

On May 26, 2009, Dr. refilled Lorcet, Baclofen, Feldene, and Restoril.

On June 3, 2009, the request for CPMP was denied with the following rationale: *"This is a five-month old injury treated with PT and one ESI with 50% pain reduction reported. There is now a request for a full CPMP, but this is premature and not consistent with Official Disability Guidelines (ODG). Additional injections are likely and he has had no secondary level physical rehab. There is no objective physical assessment and no individualized physical rehab plan of care. The mental health evaluation states he has had psychotherapy, but there has been no behavioral services requested for preauthorized so far, and no*

*discussion of what type of therapy and outcome. There is no evidence of medication overuse. There is depression, anxiety, and fear of re-injury, but this can be addressed with individual cognitive behavioral therapy or in work hardening if he has a job still. This request is not medically necessary or consistent with ODG.”*

In response to the above denial, M.D., commented that Mr. required the medical services that were only available in a CPMP in order to address the psychological component of his injury, achieved clinical MMI, return to gainful employment and to achieve case resolution. On this basis, reconsideration for 20 sessions of CPMP was requested.

On June 15, 2009, reconsideration for the request of CPMP was denied with the following rationale: *In this case the patient’s injury is only xxx month old and he has received PT services and had a fairly good response to one lumbar ESI. Documentation notes individual therapy has been completed, but review of claim does not report any authorization for injection therapy and documentation regarding the therapy and response is not submitted for review. MRI and EMG reports were not submitted for review. ODG guidelines note that CPMP are recommended as when a patient has a significant loss of ability of function independently resulting from the chronic pain and previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. In this case the pain source is not clearly defined and exhaustive treatment is not evident. Medical necessity of this request is not established.*

On June 26, 2009, the patient was seen by Dr. who reported the following: *The patient had been treated with medications, therapy, physical rehabilitation, and injection therapy. He had chronic pain, functional deficits, and a secondary depressive reaction. He had been treated with individual psychotherapy and antidepressants. He also had sad mood, self dislike, loss of pleasure, crying, agitation, loss of interest, indecisiveness, irritability, fatigue, inability to relax, fearfulness, nervousness, pessimism, and worry about his future. He did not have adequate pain and stress management skills and as a result he had not been able to bring his anxiety and depression to manageable levels. His BDI was 29/63, BAI was 30/63, and GAF was 58. He needed more aggressive intervention to control his depressive reaction. He needed specific pain and stress management training so that he would be more functional while dealing with his pain on a daily basis. He also needed to undergo significant vocational readjustment. Other treatment options had been exhausted. Dr. recommended that the patient undergo CPMP to address the psychological component of his injury. The patient required the medical services that were only available in a CPMP in order to address the psychological component of his injury, achieve clinical MMI, and to help the patient to return to gainful employment. Dr. therefore appealed the denial for 20 sessions of CPMP.*

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

Patient with simple lumbar disc injury, radiculopathy, responsive to steroids, who is a candidate for interventional treatment. A number of psychological factors have been attributed to the mechanism, type, character, and onset of injury

without any supporting explanation in the records reviewed as how they could be related to in time and causality to the injury, in addition to a lengthy but contradictory list of self-reported symptoms.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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

Gross DP, Battie MC. Predicting timely recovery and recurrence following **multidisciplinary rehabilitation** in patients with compensated low back pain. *Spine*. 2005 Jan 15;30(2):235-40.