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Notice of Independent Review Decision

DATE OF REVIEW: July 27, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5xwk x 2wks-lumbar (8hrs/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 the health care services in dispute.

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who on xx/xx/xx, lifted a 200-300 pound tarp from the bed of his truck and twisted to the right. He was unable to bring his body back up and experienced severe sharp pain in his lower back.

Following the injury, the patient was evaluated at emergency room (ER). X-rays of lumbar spine revealed minimal narrowing of the L1-L2 disc space and moderate osteophyte formation. X-rays of the thoracic spine were unremarkable. The history was positive for hypertension and gastroesophageal reflux disease. The patient was treated with intramuscular injections of Toradol and Norflex. Magnetic resonance imaging (MRI) of the lumbar spine revealed very minimal narrowing of the L1-L2 disc space with associated anterior osteophyte formation. Two days later, _____, M.D., discharged him with pain medications, anti-inflammatories, and muscle relaxants.

_____, M.D., noted positive straight leg raise on the right. He reviewed MRI of lumbar

spine and noted two-level disc desiccation at L4-L5 and L5-S1 and possibly a mild right lateral disc protrusion at L5-S1. He assessed low back and right leg pain consistent with L5-S1 radiculitis and performed L5 and S1 selective epidural steroid injection (ESI). The patient underwent six sessions of post injection physical therapy (PT) and also attended chiropractic therapy. He did not improve with ESI or PT.

A lumbar discogram revealed posterior annular tear in the L5-S1 disc with mild bulge causing concordant low back pain, posterior annular tear in the L4-L5 disc causing concordant low back pain. The post discogram computerized tomography (CT) of the lumbar spine revealed right posterior annular tear at the level of L3-L4, right posterolateral disc protrusion and associated annular tear at L5-S1, and possible left posterolateral annular tear at L5-S1. X-rays of the lumbar spine revealed focal spondylosis at L2 manifested by anterior osteophyte formation.

, D.C., treated the patient with two sessions of spinal decompression therapy, which aggravated the low back pain. , M.D., noted the patient had a lumbar injury in 2005 which was resolved with lumbar injections. He obtained electromyography/nerve conduction velocity (EMG/NCV) of lower extremities which was unremarkable. , M.D., a neurosurgeon, diagnosed lumbar disc displacement, lumbar degenerative disc disease (DDD), and lumbar radiculopathy.

On January 18, 2008, Dr. performed laminectomy decompression at L4, L5, and S1 and posterior lumbar fusion at L4-L5 and L5-S1. Postoperatively, he provided a bone growth stimulator, LSO brace, and a transcutaneous electrical nerve stimulation (TENS) unit. The patient had near complete resolution of preoperative symptoms, however; he had exacerbation of peri-incisional muscle spasms. Dr. assessed hardware malfunction with loosening of the right sided interconnecting rod and washer system. CT of the lumbar spine revealed status post posterolateral fusion and disc graft placement L4-S1, without solid bony fusion involving the disc spaces of L4-L5 and L5-S1, annular disc bulge at L3-L4 with mild-to-moderate effacement of the thecal sac, and right L5 pars defect.

On May 16, 2008, , M.D., performed removal of the previously placed instrument and re-application of the pedicle screw and rod device. The patient had persistent pain and discomfort. He was treated with tramadol and Flexeril. CT scan of the lumbar spine revealed wide bilateral laminotomies at L5, interbody fusion grafts at L4-L5 and L5-S1 without definitive signs of solid fusion, 6-mm combination of disc and spur extending into the far right lateral region of L3-L4 contacting the right L3 nerve root beyond the foramen, 6-mm left posterior lateral osteophytes at L2-L3 extending into the far left lateral region contacting the left L2 nerve root with a very minimal displacement, and suspected granulation tissue with the right posterolateral aspect on the spinal canal at L5-S1.

Dr. recommended PT three times a week for three-to-four months and possible spinal cord stimulator (SCS) trial. In a psychological evaluation , Ph.D., diagnosed mild dysthymia associated with work injury and felt the patient was a good candidate for SCS. The patient had follow-up visits with , D.C., who continued stretching exercises and opined the symptoms were direct result of work injury and treatment to date was necessary.

After a successful trial of SCS, on November 18, 2008, Dr. performed implantation of Medtronic SCS at L1-L2 and T12-L1.

On December 2, 2008, , M.D., a designated doctor, assessed clinical maximum medical improvement (MMI), and assigned 10% whole person impairment (WPI) rating.

 , M.D., assessed failed back surgery syndrome, lumbar radicular syndrome, and depression due to chronic pain and life changes. She treated the patient with medications including Pristiq, Flexeril, Celebrex, Prilosec, Lidoderm patch, Ultram ER, and Cymbalta and recommended a chronic pain management program (CPMP). Dr. treated the patient with therapy while Dr. adjusted and reprogrammed the SCS.

In January 2009, , L.P.C., noted the patient scored 39 on beck depression inventory (BDI) consistent with severe depression and 20 on beck anxiety inventory (BAI) consistent with severe anxiety. He diagnosed chronic pain disorder associated both psychological features and general medical condition and major depressive disorder and recommended CPMP.

In a functional capacity evaluation (FCE), the patient qualified at a sedentary physical demand level (PDL) versus a heavy PDL required by his job. The evaluator recommended a functional restoration program to improve activity tolerance and range of motion (ROM).

On February 11, 2009, Dr. performed intraoperative repositioning of the right lead and complex programming.

From March through April, the patient had four follow-up with Dr. who managed him with Cymbalta and individual counseling. In a subsequent FCE performed on May 4, 2009, the patient qualified at a sedentary PDL versus a heavy PDL required by his job. The evaluator recommended completing functional restoration program.

Per utilization review dated May 21, 2009, the request for 10 sessions of CPMP was denied with following rationale: *“Records reflect there are significant negative predictors of efficacy for this claimant to include high levels of psychological distress, financial issues, lack of adequate support group, increased duration of disability time, high prevalence of opioid use, and elevated pre treatment levels of pain. ODG recommends these factors be addressed prior to entrance into the program. This claimant has been disabled for greater than 24 months which is a significant negative factor for these programs.”*

From May through June, Dr. saw the patient frequently and appealed for CPMP. In response to denial of CPMP, he opined: The patient had following as a result of injury: a chronic pain syndrome with loss of function, secondary physical deconditioning, and withdrawal from family and social activities. He had developed the sequelae of depression related to injury. He had no sign of a personality disorder. Previous methods to control his pain including lumbar injections, lumbar fusion, lumbar SCS had failed to produce a significant reduction in pain or disability.

Per reconsideration review dated June 16, 2009, the request for 10 sessions of

CPMP was denied with the following rationale: *“Although the ODG advocates pain management, the submitted clinical information is deemed insufficient in justifying the request for pain management and evaluation. There is no objective recommendation of the patient’s failure to respond conservative measures that was submitted for review. There is need for a summary of prior interventions and conservative treatment to date with benefits, including physical therapy progress reports and medications summary. The records submitted for review also fails to provide evidence of continued use of prescription pain medications (particularly those that may result intolerance, dependence or abuse) without evidence of improvement in pain or function. There is also insufficient evidence to suggest the program would be effective. There are no notes indicating attempts to wean off the pain medications or indications of drug screening for compliance. Medical necessity is not established at this point in time.”*

On June 22, 2009, Dr. evaluated the patient for progressive weakness in the lower extremities. Since the revision, the stimulator was definitely working much better. Dr. ordered myelogram/CT, EMG/NCV studies of both the lower extremities. He stated the patient was totally disabled for gainful employment and was on social security.

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

The patient has had multiple previous surgeries, spinal cord stimulation, and medications. Patient has already made a decision on record to accept total disability. The patient has no reported findings which meet entry criteria for a functional restoration program, and the failure as described in the records, of previous treatments suggests the high likelihood of failure from this treatment as well.

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)

Robinson JP, Fulton-Kehoe D, Franklin GM, Wu R, Multidisciplinary pain center outcomes in Washington State Workers' Compensation, *J Occup Environ Med.* 2004 May;46(5):473-8.

Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. *Cochrane Database Syst Rev.* 2003;(2):CD002194.

McGeary DD, Mayer TG, Gatchel RJ. High pain ratings predict treatment failure in chronic occupational musculoskeletal disorders. *J Bone Joint Surg Am.* 2006 Feb;88(2):317-25.