

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: May 6, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of chronic pain management program

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 Chiropractic. The reviewer is certified by the National Board of Chiropractic Examiners. The reviewer has been in active practice in the state of Texas for over 22 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (03/26/09 – 04/08/09)
- FCE (03/23/09)
- Utilization reviews (04/03/09 and 04/13/09)

TDI

- Utilization reviews (04/03/09 and 04/13/09)
- Office visits (05/29/08 – 06/11/08)
- Diagnostics (05/21/08 – 06/06/08)

ODG criteria have been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was working with another employee who was passing a compactor down to him. The other individual let go prematurely and the patient absorbed the brunt of the weight of the machine. He stated he further injured himself while getting

out of the ditch and experienced pain in the lower back radiating down to the left leg. The incident occurred on xx/xx/xx.

In May 2008, magnetic resonance imaging (MRI) of the lumbar spine was obtained for pain in the back, which revealed: (1) Multilevel lumbar spondylosis, a broad central disc herniation (extrusion type) at L4-L5 and a left central to left subarticular disc herniation (extrusion type) at L1-L2 with moderate spinal canal stenosis at L4-L5 and mild spinal canal stenosis at L3-L4 and moderate left foraminal narrowing at L4-L5. (2) Grade I anterolisthesis of L5 on S1, probably on the basis of bilateral pars defect at L5.

M.D., noted low back pain and excruciating pain in the right groin with pain radiating to the right testicle associated with frequent urination, and excruciating pain in both the lower extremities. The patient had been prescribed Duracet, but was unable to tolerate it. History was positive for lumbar laminectomy and fusion in 1988. Examination revealed a fairly large transverse scar in the lumbar region from previous surgery, strongly positive straight leg raise (SLR) on the left with tenderness over the left sciatic notch, cross leg raising from right to left, hyperactive reflexes, and absolute reflexes in the Achilles, decreased left knee jerk, reduction in the pinprick sensation to the posterior part of the left leg, and considerable weakness of the hamstring muscles on the left. Dr. assessed posttraumatic herniated L4 disc, spondylosis at L5-S1 and L4-L5 associated with herniated disc and multilevel changes in the upper part of the lumbar spine; prescribed Vicodin and Fexmid, and recommended surgery as soon as possible, which was deferred by the patient who wanted to continue conservative treatment consisting of physical therapy (PT) under the guidance of Dr.

In June, M.D., issued prescriptions for baclofen, Mobic, carisoprodol, gabapentin, tramadol, Medrol Dosepak, and facet blocks in the lumbar region.

X-rays of the lumbar spine revealed advanced L5-S1 spondylosis with severe disc space narrowing, eburnation and osteophyte formation with lower lumbar facet arthropathy. X-rays of the pelvis were unremarkable.

On follow-up, Dr. noted he had evaluated the patient in regard to his chronic residual posttraumatic mechanical-type lumbosacral pains associated with bilateral radicular pains at the S1 over the left lower extremity with pain traveling to the S1 nerve root from the low back all the way down to the left calf. The patient also had bilateral L5 radicular pain following the anterolateral aspect of the thighs as well as the groins down to the testicles due to mainly the right leg more than the left. The involvement of radicular sciatic radiation was actually at two levels, the L5-S1 involving the S1 nerve root, the L4-L5 levels bilaterally involving the right more than left following the L5 nerve roots. This type of radicular sciatic irritation was also with intermittent paresthesias and cramping. The patient had begun his treatment with Dr. in the beginning and was placed on medications. He was utilizing a cane and examination revealed decreased range of motion (ROM) of the lumbar spine, positive bilateral SLR producing bilateral L5 pain on the right and left-sided radicular S1 pain, and decreased pinprick sensation involving the L5 and S1 nerve roots bilaterally due to chronic bilateral sciatic radiculitis. Dr. opined the pain was really due to a mechanical bending and twisting injury of the articular surface, which could account for bilateral irritative radicular sciatic pain as well as accounting for two types of level of pain and nerve roots. Dr. continued the patient on transcutaneous electrical nerve stimulation (TENS) unit and recommended conservative therapy consisting of ultrasound, hot packs, and local therapy; use of aqua exercises, and progressive swimming activities; and articular facet blocks.

In March 2009, an electrodiagnostic consultation was conducted by M.D., who noted the following treatment history: *Initially, the patient was treated by Dr. with few intramuscular injections and was released back to work. He was subsequently treated by Dr. who obtained magnetic resonance imaging (MRI) of the lumbar spine. History was positive for a lumbar fusion surgery for a fractured vertebra. On July 25, 2008, he underwent a lumbar hemilaminectomy at L4-L5 on the left with interbody discectomy and decompression with subtotal facetectomy at L4 and redo of an L5 laminectomy. Electromyography/nerve conduction velocity (EMG/NCV) study of the lumbar spine revealed chronic left L5 and S1 radiculopathy. Dr. suggested a trial of left L5 and S1 nerve root block.*

In a functional capacity evaluation (FCE) performed on March 23, 2009, the patient qualified at the light physical demand level (PDL) versus medium to heavy PDL required by his job.

Dr. noted the patient walked with the aid of a cane and had been given 5% disability rating. Dr. opined the patient was totally disabled for any type of gainful employment.

A psychological evaluation was conducted by Ph.D., and the patient was diagnosed with pain disorder associated with psychological factors and a general medical condition, chronic adjustment disorder with mixed anxiety and depressed mood, and sleep disorder due to a general medical condition. The patient scored 29 on the Beck Depression Inventory (BDI) and 25 on the Beck Anxiety Inventory (BAI). The evaluator recommended chronic pain management program (CPMP).

On April 3, 2009, Dr. denied the request for 10 sessions of CPMP with the following rationale: *Records indicate the employee was placed at MMI with 5% impairment rating (IR) by a TDI-DWC appointed DD as of March 17, 2009; and since the copy of the DD report has not been provided it is not clear as to whether the DD addressed the medical necessity for any additional treatment or not. An FCE was performed on March 23, 2009, which once again reports the employee is performing in the heavy PDL on static strength system (NIOSH); no dynamic testing appears to have been performed or documented; and the results of this testing is inconsistent with the report dated March 24, 2009, by Dr. which states the employee is totally disabled for any type of gainful employment. In addition, Dr. has stated that the employee refuses to undergo any additional surgery, but the FCE report notes that due to positive EMG/NCV, he might be a candidate for another surgery and there is no written documentation to confirm this statement. The patient is currently not working and it does not appear that any attempt has been made to allow the employee to return to work based on the FCE results of January 13, 2009, or March 23, 2009; or that the employee has a job to return to; or that the employer is unwilling to accommodate a return to work for the employee. According to Dr., the employee has no intention of returning to work for the same employer and may be going through DARS for retraining. Finally, it is noted that a formal CPMP is not necessary in order to wean a patient off prescription medications."*

On April 13, 2009, Dr. denied the appeal for 10 sessions of CPMP. The reconsideration utilized the same clinical review criteria and treatment standards referenced in the earlier review. The rationale would be available on written request.

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

Based on the records, the claimant is an male who experienced an episode of pain in the lower back on xx/xx/xx while working . The claimant has a previous history of a lumbar spine injury that led to surgery. The claimant had additional lumbar spine surgery on 07/25/08 as a result of the xx/xx/xx injury. Neurodiagnostics demonstrated chronic radiculopathy at L5 and S1. FCE on 03/23/09 reported that the claimant was around the light physical demand level while his lifting abilities placed him in a much higher PDL. Based on the records, it appears that the claimant has no intention of working for the employer where the injury occurred and is planning to receive re-training from DARS. A chronic pain management program was requested by, DC the claimant's treating doctor. However, based on the 03/23/09 FCE, the claimant demonstrated he had significant physical capabilities. This does not support the assessment from the psychotherapist that the claimant has a significant loss in ability to function independently. The psychotherapist reported that the claimant is extremely motivated to return to work yet there was no evidence of that in the records considering the claimant's functional ability. ALL the criteria for the chronic pain management program outlined by ODG are not satisfied and do NOT support the requested CPMP.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**