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Notice of Independent Review Decision

DATE OF REVIEW: October 2, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

BHI-2 psychosocial screening

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance:

- Utilization Review (09/03/09 – 09/15/09)

M.D.

- Office notes (10/22/08 – 08/20/09)
- Diagnostics (11/20/08, 08/20/09)
- RME (05/11/09)

- Second opinion on MRI (01/14/09)
- Peer Review (02/04/09)
- RME (03/11/09)
- Utilization Review (09/03/09 – 09/15/09)
- DDE (05/06/09)

ODG criteria have been used for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female. She was injured on xx/xx/xx, when she did not notice a box placed at her feet and lost her footing. She slipped and fell injuring her lower back, neck, and right arm.

Initially, the patient presented to emergency room (ER) where she was told that there were no fractures on x-rays and was discharged home. She subsequently sought treatment from, M.D., who obtained more x-rays and treated her with physical therapy (PT) and medications including Darvocet-N, Ultram ER, Mobic, and Flexeril for cervical spine, right shoulder, and right hip sprain; lumbar radiculitis; and contusion of right lower leg.

Magnetic resonance imaging (MRI) of the lumbar spine revealed moderately stenotic central canal and lateral recesses bilaterally at L4-L5 secondary to broad-based central disc protrusion superimposed on mild spondylosis, annular disc bulging, and moderate bilateral ligamentum flavum hypertrophy; borderline stenosis of the central canal at L3-L4; and varying degree of stenosis of the neural foramina bilaterally from L2-L3 through L5-S1, worst at L4-L5.

In February 2009, M.D., performed the demonstrated abilities evaluation (DAE) in which the patient did not give the efforts that were compatible with activities of daily living on functional examination.

M.D., performed a required medical evaluation (RME) and opined: (1) The patient had had extensive PT without any benefit. There was no point offering anymore therapy. It was inappropriate to treat her with multiple medications, almost five months subsequent to the injury, without any objective evidence of significant pathology. Appropriate medications would include over-the-counter (OTC) analgesics or anti-inflammatories on a p.r.n. basis. (2) There was no significant pathology demonstrated that should require ongoing treatment. Further, a DAE revealed that the patient did give a very poor effort. She should be returned to her workplace as rapidly as possible.

In a designated doctor evaluation (DDE), M.D., noted history was positive for diabetes since 10 years and hypertension. She assessed clinical maximum medical improvement (MMI) as of May 6, 2009, and assigned 0% whole person impairment (WPI) rating. She obtained a functional capacity evaluation (FCE) in which, the patient qualified at a light physical demand level (PDL) versus a medium PDL required by her job. Dr. stated the patient could return to work with restrictions.

M.D., an orthopedic surgeon, saw the patient for severe, 9/10 lumbar pain radiating down her both legs, but primarily on the right. The patient reported problems with constipation and urinary retention in the morning. Examination revealed positive straight leg raise (SLR) on the right, some numbness in the buttocks, diminished sensation along the L5 and S1 bilaterally, but primarily more so on the right, weakness of the extensor hallucis longus (EHL) and toe flexors on the right, and 2+ and symmetric patellar reflexes, but absent Achilles reflexes bilaterally. Review of MRI showed disc herniation at L4-L5, which was large and in the central canal. The radiologist measured it as being 6 mm, but in light of the fact that the patient had some mild congenital central stenosis, this was quite a significant finding. Dr. diagnosed large herniated nucleus pulposus (HNP) at

L4-L5, neurogenic bladder, and radiculopathy and recommended lumbar laminectomy and microdiscectomy at L4-L5, but this was not authorized.

A second opinion was sought by, M.D., on the MRI of the lumbar spine. She interpreted: (1) Moderate posterior disc bulge at L4-L5 with a small 3-mm broad-based posterior central protrusion effacing the anterior thecal sac, moderate central stenosis, moderate bilateral facet degeneration, and moderate bilateral foraminal narrowing. (2) Mild bilateral facet degeneration at L5-S1, mild bilateral foraminal stenosis, mild posterior disc bulge at L3-L4, and borderline central canal stenosis.

On July 1, 2009, an IRO was performed where spinal surgery was disputed and the denial was upheld. Rationale: *There was no indication for surgery. The patient was found to be neurologically intact with an age consistent MRI. There were no focal deficits and there were no acute or traumatic effects found on the MRI.*

On August 20, 2009, Dr. noted the patient continued to have a positive SLR on the right, some diminished sensation along the right L5 distribution, absent Achilles reflexes bilaterally. He stated that although sometimes the disc herniations caused continuous compression on the nerve roots, in some cases, there was intermittent compression and neurogenic claudication occurred when there was an intermittent compression on the nerve roots. He therefore recommended obtaining a psychosocial screening to help establish if she had any psychosocial barriers to recovery. Dr. further stated that Dr. had documented lack of atrophy, which was consistent with intermittent compression such as neurogenic claudication. The IRO physician did not indicate in any part of his report how he found that the patient's clinical presentation was inconsistent with neurogenic claudication. Dr. therefore wanted to resubmit his request for surgery once he had the new medical information. As the deadline for Contested Case Hearing (CCH) was missed, a request for surgery was to be resubmitted once the medical information was obtained. He recommended going ahead with computerized tomography (CT) myelogram to help show nerve root compression, which would be consistent with the patient's complaints and findings.

On September 3, 2009, a request for BHI-2 psychosocial screening was not authorized with the following rationale: *"The patient has had injury date of xx/xx/xx. She has had diagnostics, PT, and medications. Surgery was denied x2 and at IRO and CPMP was denied in August 2009. A DDE on May 6, 2009, put patient at MMI with 0% impairment rating (IR) and recommends the patient return to work at light duty. Her current medications included hydrocodone, Mobic, Flexeril, and Cymbalta. The patient has a psychological evaluation on August 5, 2009, prior to the request for chronic pain management program (CPMP) and then participated in it with a discharge summary from it dated August 25, 2009, noting a pain level of 6/10 and a Beck Depression Inventory (BDI) of 46. A note from Dr. dated August 20, 2009, recommends that the patient have a psychological evaluation and CT/myelogram with a plan to resubmit for surgery. It was not clear why the patient would need psychological testing if she was evaluated last month and CPMP was denied. It was done and surgery has been denied already. Based on the available information, the request does not appear to be reasonable and necessary, per evidence-based guidelines."*

On September 15, 2009, appeal for BHI-2 psychosocial screening was denied with the following rationale: *“This is a female who tripped and fell on her right arm and leg injuring her neck and low back. An MRI dated November 20, 2008, reported L3-L4 mild disc bulge with moderate central protrusion at L4-L5 and moderate central stenosis. There was also moderate bilateral facet degeneration at that level, and mild facet degeneration at L5-S1. An RME on March 11, 2009, reported that the patient was not giving a good effort, and felt there was no point in offering more therapy, as the patient had not demonstrated any benefit. This report also suggested OTC medications. The claimant was recommended for lumbar laminectomy, microdiscectomy, and annular patch, however, this was denied. An IRO upheld denial of this surgery. Apparently the treating doctor was pursuing a CCH and possible future surgery. The claimant reports 7-10/10 pain, BDI is 64, Beck Anxiety Inventory (BAI) is 29. Apparently, she has pain throughout the entire right side of her body upper and lower extremities as well as cervical and lumbar spine. Prior physical examination did note some EHL and toe flexor weakness on the right. On August 31, 2009, the claimant had an approval for 10 sessions of CPMP. The clinician had not indicated the clinical necessity for the additional psychosocial screening when the claimant has undergone psychological evaluation and individual psychotherapy. The clinician appears to be requesting reconsideration for a surgical procedure, which would require psychological evaluation. However, based on the evaluations and care to date, it would not appear to be necessary for reevaluation of psychosocial issues prior to a surgical request. This request is not indicated.”*

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

Based on the records received, the MRI was consistent with age, RME reported lack of effort, her complaints of upper and lower body pain would not be related to the reported injury, the DD found her to be at 0% WPI indicating no residual, she has completed psychological evaluation and individual psycho therapy, surgery has been denied and there does not appear to be a surgical lesion and ten sessions of CPMP approved. Per ODG prior to approval for CPMP a psychological evaluation should be performed and should include “evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient’s pain”. The request is not indicated based on the evaluations and care to date.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES