

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: October 12, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pain management 5 x Wk x 2 Wks

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

Diplomate American Board of Physical Medicine & Rehabilitation
Subspecialty Board Certification in Pain Medicine
Diplomate American Board of Electrodiagnostic Medicine
Member-ISIS, ASIPP

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

- Office visits (11/08/08 - 08/10/09)
- Diagnostics (10/17/07 - 07/15/09)
- Utilization reviews (08/17/09 – 09/08/09)

TDI

- Utilization reviews (08/17/09 – 09/08/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury on xx/xx/xx, while lifting a forklift tire off the ground when another one fell from above striking him at the back of the neck. He fell to the floor and experienced pain in the neck, thoracic spine, and low back.

In xx/xxxx, magnetic resonance imaging (MRI) of the cervical spine revealed 1-2 mm disc protrusion at the C3-C4 and C5-C6 levels pressing on the thecal sac and a 2 mm herniated nucleus pulposus (HNP) at C6-C7 pressing on the thecal sac.

In February 2008, x-rays of the thoracic spine were unremarkable and x-rays of the lumbar spine revealed facet arthropathy at L4-L5 and L5-S1, predominantly on the left side. MRI of the lumbar spine revealed dehydration of the L5-S1 disc, moderate disc space narrowing at L5-S1, focal hyperintensity in the anterior superior T11 vertebral body consistent with probable hemangioma, type II changes in the bone marrow adjacent to the L5-S1 disc space; a 1-2 mm posterior disc protrusion at L4-L5 approaching the anterior thecal sac at the midline and pressing on the anterior aspect of the L5 nerve root bilaterally; and a posterior 2-3 mm disc protrusion at L5-S1 extending more to the right than left of midline approaching the anterior aspect of the right S1 nerve root.

MRI of the thoracic spine was unremarkable.

In November 2008, M.D., evaluated the patient for complaints of pain localized to the right side directly over the iliac crest with radiation of pain intermittent down the right lower extremity with associated numbness and tingling both to the top of the foot and sole of the foot. The patient also complained of left-sided pain from time to time in a very similar distribution and reported exacerbation with Valsalva maneuver such as coughing, sneezing, and straining with weakness in left lower extremity. Dr. noted that the patient had undergone three epidural steroid injections (ESIs) for the lumbar spine and had attended physical therapy (PT). Electromyography/nerve conduction velocity (EMG/NCV) study performed in July had shown irritation of the right L5 and S1 nerve roots. Examination revealed pain to the right of the midline and tenderness on palpation about the area and straight leg raise (SLR) reproducing discomfort in the back bilaterally. Dr. obtained x-rays of the lumbar spine that were unremarkable. He assessed soft tissue injury to the lumbar spine and stated there was no true radiculopathy. He stated the patient did not have a surgical lesion and recommended a work hardening program (WHP) for four weeks.

In January 2009, M.D., an orthopedic surgeon, noted that the patient had undergone three lumbar ESIs and one cervical injection. Examination revealed decreased cervical ROM with increased pain and axial compression of the cervical spine, midline tenderness, and some spasms with diminished sensation along the left C7 distribution. Examination of the lumbar spine revealed tenderness in the midline with painful forward flexion, and SLR eliciting back pain bilaterally. Dr. assessed discogenic lumbar pain at L5-S1 and possible cervical disc herniation. He stated the patient had been injured for over xxxx and there might be psychological factors which might interfere with recovery. He recommended a psychological screening.

On June 30, 2009, the patient was seen by Dr. and was referred for a functional capacity evaluation (FCE) and chronic pain management program (CPMP).

On July 15, 2009, M.Ed., L.P.C., saw the patient in a behavior medical assessment. He scored 8 on Beck Depression Inventory (BDI) consistent with nonsignificant depression. Mr. assessed adjustment reaction secondary to

chronic pain syndrome and recommended 30 days of multidisciplinary pain management program. The patient underwent a functional capacity evaluation (FCE). FCE report indicated the patient was utilizing Vicodin, hydrocodone, and Lyrica for pain management. He had attended PT over a 10-month period and reported some pain relief. He was recommended CPMP.

On August 9, 2009, the patient underwent EMG of left upper extremity; however, the results are not available.

On August 17, 2009, per utilization review, M.D., denied a request for 10 days of CPMP with the following rationale: *The behavioral medicine assessment acutely recommends a 30 day program. The request appears to be for 10 initial visits. The records do not reflect the medications the claimant is on. The request is not indicated.*

On September 3, 2009, Mr. saw the patient at Physical Therapy. He indicated that the FCE had shown decreased left shoulder, cervical, and lumbar active ROM. The patient was physically unable to perform physical assessments/performance testing secondary to increased pain in the left shoulder and lumbar spine. In a behavioral assessment, the patient reported his pain levels as 7/10. He was also experiencing distress in the form of depression, worry, boredom, reduced desire for sexual activity, and reduced sleep. In response to the denial, he opined that the patient did not have a history of addiction and it was not suspected at that time. The patient was utilizing hydrocodone q. 6hours and tizanidine q.i.d. Mr. recommended reconsideration for a 20 day multidisciplinary pain management program.

On September 8, 2009, per utilization review, D.O., denied the appeal for CPMP with the following rationale: *This patient sustained an injury on xx/xx/xxxx. The clinical notes sent for review did not provide objective documentation of the patient's failure to respond to conservative measures such as physical therapy, medications, and exercises. The clinical information did not include objective documentation that the previous methods of treating the chronic pain have been unsuccessful and that there is an absence of other options likely to result in significant clinical improvement. There were no physical therapy progress notes or reports to objectively indicate that there is failure to respond to such conservative treatments. Additionally it is not clear if the patient underwent any individual psychotherapy or trials of antidepressant/anxiety medications that failed to provide any benefits to the patient. As such, the medical necessity is not determined at this time.*

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

The information indicates the patient meets criteria for chronic pain greater than 6 months and failure of primary and secondary levels of care. The use of PMP is supported by ODG provided the treatment is multidisciplinary and functional goal directed. In this instance, the goal is RTW and detox from opiates. 2 weeks of PMP is reasonable per ODG to resolve this chronic soft tissue strain.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**