

# MATUTECH, INC.

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

---

## Notice of Independent Review Decision

**DATE OF REVIEW:** October 26, 2009

**IRO CASE #:**

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

Chronic pain management program x 10 days/sessions

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

Board Certified Diplomate, American Board of Physical Medicine and Rehabilitation with subspecialty certificate in pain medicine

**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**

**TDI**

- Utilization reviews (08/28/09, 09/28/09)
- Office visits (03/05/09 – 09/18/09)
- PPE (08/12/09)
- Utilization reviews (08/28/09, 09/28/09)
- Office visits (03/05/09 – 09/18/09)
- PPE (08/12/09)
- Utilization reviews (08/28/09, 09/28/09)
- Office visits (10/24/07 – 09/09/09)

**ODG criteria have been utilized for the denials**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported bilateral wrist and hand pain on xx/xx/xx due to repetitive type injury.

2007: On October 24, 2007, M.D., performed a peer review. *He noted a day after the injury; the patient was treated at Medical Center for pain in the hands while using a rivet gun. The patient had been seeing Dr. for a trigger finger on his left hand and also the third, fourth, and fifth fingers of the right hand had begun locking on him. In September 2007, he was seen by , D.C., and had been allowed to work with restrictions. Dr. diagnosed right and left carpal tunnel syndrome (CTS) and recommended neurodiagnostic studies.* Dr. rendered the following opinions: (1) It was difficult to establish a diagnosis based on Dr. 's note of September 24, 2007. Tenosynovitis and trigger fingers might be produced or at least aggravated by repetitive work activity. A separate diagnosis of CTS would not be causally related to a tenosynovitis and trigger diagnosis for November 6, 2003. (2) It was probable that the patient had pre-existing fluid retention in his hands associated with Dupuytren's fasciitis and pre-existing carpal arthritis of the wrist or prior injury to the wrist with carpal dissociation that caused secondary swelling and thus, secondary tenosynovitis triggering and possibly even CTS. (3) The injury sustained on xx/xx/xx, had resolved. (4) The current complaints were not causally related to the original injury of xx/xx/xx. (5) The request for neurodiagnostic studies would not be standard. (6) There was no indication for surgical care. (7) There were no indications for further diagnostic studies, durable medical equipment (DME), pain management, work hardening program (WHP), or follow-up visits. (8) There was no indication that medications were needed. (9) There were no indications for additional physical therapy (PT) or chiropractic treatments.

2008: Dr. evaluated the patient for pain in the right shoulder radiating down the right arm; numbness and tingling in the right shoulder and right upper wrist; stiffness and soreness in the right shoulder region; and joint pain and tightness in the right shoulder. There was dysfunction in the wrist, severe weakness, poor range of motion (ROM) of the wrist, positive Tinel's and Finkelstein's, and decreased ROM in the wrist areas. Electromyography/nerve conduction velocity (EMG/NCV) revealed median nerve compression bilaterally. Dr. referred the patient to M.D., for the need of surgery and to D.O., who agreed with previous findings.

2009: The patient attended two sessions of PT.

In March, Dr. evaluated the patient for occasional pain to the right middle finger. The patient had approximately 10 degrees of full extension at the tip.

Dr. noted pain in the region of the right shoulder radiating down the arm, stiffness and soreness in the right and left hand, joint pain, and tightness in the right shoulder. The patient had returned after having surgery by Dr. on December 13. He was now participating in postsurgical rehab. Grip strength and restraints were also increasing, although it was still decreased as compared to the norms. EMG/NCV study revealed median nerve compression bilaterally. Dr. referred the patient back to Health for his pain issues that inhibited his sleep.

In April, Dr. noted tenderness in the right and left wrist/hand joint, spasms affecting the right and left brachioradialis, and decreased ROM of right and left wrist. He assessed that the patient had made steady progress, though significant functional limitations remained and recommended continuing rehabilitative exercises.

In May, Dr. noted the patient continued to have severe numbness, pain, and loss of strength in both hands. Phalen's, Tinel's and compression tests were positive in both the right and left wrists. Two-point discrimination was greater than 15 mm to the right and left thumbs, index, and middle fingers. Dr. diagnosed bilateral carpal tunnel and recommended decompression of the right median nerve.

Ph.D., a licensed psychologist, noted the patient had sustained a compensable injury to his right and left hands and shoulder. He had to retire in 2005 due to his inability to continue doing his job. He had previous injuries to his left shoulder and had a right rotator cuff surgery done. Subsequently, he had bilateral trigger releases of his left and right middle fingers with release of A1 pulley bilaterally in October 2008 on his left hand and on December 2008 on his right hand. He had participated in postoperative PT that helped little in regaining functioning of his hands. D.O., determined that the patient had not reached maximum medical improvement (MMI). The EMG report demonstrated bilateral CTS and this appeared to be the current problem. The patient had surgery for this condition scheduled for May 22, 2009. Currently, he complained about increased pain in both hands and emotional distress because of continuous limitation. He was currently using Tekturna, hydrochlorothiazide/ lisinopril, and Janumet. Between September 2006 and November 2006, the patient had received six sessions of psychotherapy for psychological distress related to work injury. Currently, the patient scored 29 on the Beck Depression Inventory – II (BDI-II), indicating severe depression and 16 on Beck Anxiety Inventory (BAI), reflecting moderate anxiety. Dr. diagnosed major depressive disorder and pain disorder associated with both psychological factors and general medical condition and stated that the patient had severe level of depression and moderate level of anxiety particularly with worries about future prospects, overall recovery, maladjustment secondary to his work injury, refractory pain, unresolved functional problems, and alterations in his lifestyle and self-perception and recommended six sessions of individual psychotherapy.

D.O., evaluated the patient for bilateral wrist and hand pain. History was significant for right shoulder surgery, back injury with loss of feeling in his legs (treated overtime); head injury requiring 27 staples in his scalp. Since the head injury, he had seizures and also some memory lapses. On examination, the wrists revealed some tenderness over the carpal tunnel and equivocal Tinel's sign bilaterally, paravertebral hypertonicity, tenderness in the lumbar spine, and indentation area on the anterior superior skull indicating previous trauma. Dr. diagnosed chronic CTS, right shoulder pain status post surgery, chronic low back pain, seizures, and memory loss secondary to head injury. The patient had been taking narcotic pain medication with no apparent increase in function for several years. Dr. felt the patient was a good candidate for chronic pain program although he had seizure disorder that was not being medicated. He had not had a seizure in some time and the only seizure he ever had were at nighttime when he was asleep.

In a physical performance evaluation (PPE), the patient functioned at a light physical demand level (PDL) as against medium PDL required by his job. A chronic pain program was recommended to achieve his return to work goals.

In August, Dr. requested a 10-day trial of chronic pain management program (CPMP).

On August 28, 2009, M.D., denied the request for CPMP with the following rationale: *“The patient is stated to have retired from the company in 2005. Mention is made that the only medication is occasional hydrocodone. BDI most recently was 5 (normal). Mention is made of an FCE showing the patient at a light PDL, with his formal job (from which he retired) requiring a medium PDL. The patient has only had 12 postoperative PT sessions. It is unclear why PT or other rehabs would not suffice. This would not meet Official Disability Guidelines (ODG), 2009 August. Additional information was not obtained to justify the program. In addition, one note states that the patient has CTS on EMG, and this does not appear to have been addressed.”*

The following records are available from a summary: *In October 2007, D.C., performed a peer review and opined that 12 visits for PT would be considered reasonable and necessary after surgical release of trigger finger. Continued chiropractic care and PT beyond this would not be considered reasonable and necessary. The patient should be performing a home exercise program (HEP). In March 2008, Dr. evaluated the patient for numbness in the median nerve distribution of both wrists with pain in the area of the carpal tunnel. The patient underwent release of A1 pulley left middle finger on October 13, 2008, by Dr. On December 8, 2008, Dr. performed release of A1 pulley of the right middle finger. A functional capacity evaluation (FCE) placed the patient at a physical demand level (PDL) of sedentary that did not meet the work required PDL of medium. Dr. released the patient to work as of July 14, 2009, with restrictions. In a follow-up visit, Dr. noted pain and numbness along with loss of strength to the upper extremities; positive Phalen’s, Tinel’s, and compression tests to bilateral wrists; significantly compromised grip strength; and resolved trigger finger. He continued conservative treatment.*

In response to Dr. ’s opinion, Dr. stated the issue of the patient retiring from his employer was irrelevant to this review. The patient’s limited use of narcotic medication was not an exclusionary factor for participation in a CPMP. The BDI-II score was rather irrelevant. The patient had endorsed fear-avoidance of activities at home [FABQ-PA score of 70.8%, as well as Oswestry score in the severe range (44.0%)]. It showed clear psychosocial impediments that needed to be addressed by CPMP. Regarding findings of CTS on EMG study, this body part was agreed to be noncompensable at a Benefit Review Conference (BRC), therefore this point raised by Dr. was null and void.

On September 28, 2009, M.D., denied the appeal for CPMP with the following rationale: *“The patient had 12 sessions of PT. The patient has had individual cognitive behavioral therapy (CBT). Most VAS scores show a gain, but the patient’s pain has not gotten any better. The patient can support more activities and has decreased medications, but is still taking some medications on a p.r.n. basis. The patient is at a light PDL. He states that the patient has functional deficits that have not improved with low-level care and CPMP is requested to*

*improve his function and endurance. There is no reason he might not participate in a CPMP although he does have a seizure disorder, which is not being medicated. Request for an initial 10 days participation in a CPMP was considered in review on August 28, 2009, and recommended for non-certification. Dr. submitted a request for reconsideration dated September 18, 2009. Per Dr. , the patient's retirement is not relevant and the limited use of narcotic medications is not an exclusionary factor. The patient's date of injury was xxxx and he has been through extensive treatment, including CBT thus far. Reportedly, the patient's VAS scores have improved, but his pain has not. It is unclear how PT and CBT in the CPMP would be more effective than the PT and CBT already provided."*

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

REVIEW OF SUBMITTED NOTES DOES NOT IDENTIFY ANY SPECIFIC OCCUPATIONAL, MEDICATION, OR FUNCTIONAL GAINS WHICH ARE CONSIDERED WIDELY ACCEPTABLE ENTRY CRITERIA FOR A VALID PAIN PROGRAM

**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)**

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.

Haldorsen EM, Grasdal AL, Skouen JS, Risa AE, Kronholm K, Ursin H. Is there a right treatment for a particular patient group? Comparison of ordinary treatment, light multidisciplinary treatment, and extensive multidisciplinary treatment for long-term sick-listed employees with musculoskeletal pain. *Pain.* 2002 Jan;95(1-2):49-63.