

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** October 28, 2009

**IRO CASE #:**

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

Chronic pain management program x 10 sessions (80 hrs)

### **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:

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**

- Office visits (01/06/09 – 10/07/09)
- PT notes (01/06/09 – 04/02/09)
- Procedure (01/13/09)
- Utilization reviews (01/27/09, 01/29/09, 10/05/09, 10/13/09)

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

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

The patient is a male who reported that he felt immediate low back pain as he pulled a hose that weighed approximately 174 pounds on xx/xx/xx.

On January 6, 2009, D.C., evaluated the patient for low back pain radiating to the gluteus maximus. Dr. diagnosed lumbar disc syndrome, lumbar radiculitis, restriction of motion of lumbar spine, and deep and superficial muscle spasms.

On January 13, 2009, M.D., performed a right L4-L5 laminotomy, discectomy, and foraminotomy. Postoperatively, the patient did well and was prescribed Ambien.

Per utilization reviews, it was noted the patient was now referred to PT status post surgery and had completed 12 postoperative PT sessions. From March through April, the patient attended five sessions of PT.

In April, a functional capacity evaluation (FCE) was performed. It was noted that *in July 2008, magnetic resonance imaging (MRI) of the lumbar spine revealed a right paracentral 4-5 mm disc herniation at L4-L5 and a 3-mm right paracentral disc herniation at L5-S1 with compression against the exiting right S1 nerve root sleeve.* The FCE placed the patient in a light physical demand level (PDL) versus medium to heavy PDL required by his job. In a psychological evaluation, the patient was diagnosed with adjustment disorder with anxiety and depressed mood and was recommended work hardening program (WHP) designed to maximize his ability to return to work. In another FCE, the patient performed at a light-medium PDL. The patient had completed 18 sessions of PT and had made significant progress.

In July, Dr. noted the patient had completed the initial 10 sessions of work hardening program (WHP) and reported to be doing well in the beginning. However, in the last couple of days he was in severe pain. He had increased lumbar paraspinal muscle guarding and spasm. The lumbar ROM was reduced due to spasm and muscle guarding. The pain traveled to the right posterior leg again and provocative tests revealed a positive Valsalva's, straight leg raise (SLR), and Bechterew's tests. Dr. felt this was a possible postsurgical disc disruption and recommended a repeat postsurgical lumbar MRI with/without contrast.

M.D., a pain management physician, noted *following the injury, the patient saw a company doctor who took x-rays and released him to work. On August 4, 2008, the patient saw Dr. who referred him to an orthopedist. Prior to the right hemilaminectomy, the patient had one lumbar epidural steroid injection (LESI) that helped the leg and back pain for one month. The patient was taking tramadol, hydrocodone/APAP, Ambien, and Celebrex. The lumbar MRI without contrast performed in July 2009 showed status post right hemilaminectomy at L4-L5 associated with focal disc protrusion and annular tear, narrowing of the lateral recess bilaterally with some neural foraminal encroachment at L4-L5, central and paracentral disc protrusion at L5-S1 on the right with slight displacement of the S1 nerve root. MRI of the lumbar spine with contrast showed: (1) Diffuse scar tissue involving anterior and lateral aspects of the epidural space with disc protrusion with scarring at L4-L5. Some narrowing of the central canal and lateral recesses at L4-L5. (2) Central and paracentral disc protrusion at L5-S1 on the right.* Examination revealed mildly limited lumbar ROM with backward bending worst at forward bending, positive lumbar facet loading bilaterally, and tenderness over the paravertebral regions bilaterally. Dr. diagnosed postlaminectomy syndrome, lumbar disc displacement, nerve root compression, and restriction of motion and prescribed a compound cream and Flexeril.

M.D., conducted a designated doctor evaluation (DDE). He noted *the patient had an orthopedic consultation by M.D., who assessed herniated disc on the*

*right at L4-L5 and L5-S1. He had suggested surgical intervention if conservative treatment failed. Follow-up evaluation showed a normal sensory examination of the lower extremities, but diminished reflexes over the L4 and L5 reflexes graded as 1+ and 2+ respectively. Lumbar ESI and lysis of adhesions was performed on October 1, 2008. A significant decrease in his leg symptoms was noted and his back pain was just a 5/10. Sensory examination was unremarkable in November 2008. After the ESI, most of the symptomatology changed from the left to the right side, which was the area of active pathology at the L4-L5 interspace. Dr. assessed maximum medical improvement (MMI) as of August 11, 2009, with 5% whole person impairment (WPI) rating. He recommended the patient to undergo an FCE to determine safe working limitations prior to returning to work to reduce the likelihood of re-injury.*

In October, Dr. noted ongoing symptoms in the lower lumbar area with radiculopathy. He substituted Lorcet with Darvocet, recommended lumbar ESI and electromyography (EMG) of the lower extremities, and stated the patient was not at MMI and needed additional treatment.

On October 5, 2009, D.C., denied the request for chronic pain management x10 sessions by Dr. with the following rationale: *“(1) The ODG DWC 2009, low back chapter states, “upon completion of a rehabilitation program (e.g. work hardening, work conditioning, patient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The patient underwent a WHP at the requesting facility and only needed to get from a light-medium PDL to medium, but this failed. According to the requesting provider, this failure requires a chronic pain management program (CPMP) to deal with the psych component. However, first, the WHP should have involved a significant psych component and second, psych values per Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) are nearly identical to those prior to the WHP. (2) An adequate and thorough multidisciplinary evaluation has been made – as only a psychological evaluation is found this requirement is not satisfied. (3) If a primary reason for treatment in the programs addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish most appropriate treatment approach. (4) It is indicated that one purpose of the requested CPMP is that patient tends to rely fully on medications to cope with his pain and depression. However, not only has there been no evaluation with an addiction clinician, there is no indication as to what medication patient is using. If any, and the extent to which this use constitutes concern in this regard. There should be documentation that the patient has motivation to change, and be willing to change their medication regimen. There should also be some documentation that patient is aware that the successful treatment in a change compensation and/or other secondary gains – there is no indication that this requirement is satisfied. (5) Negative predictors of success should be identified, and if present, the preprogram goals should indicate how these will be addressed – there is no indication that this requirement is satisfied.”*

On October 13, 2009, M.D., denied the appeal for CPMP with the following rationale: *“As per peer conversation, the patient is status post WHP with an exacerbation of pain, and the program has been requested in efforts to get more rehabilitation for the patient. However, the patient does not meet the criteria for enrollment into a multidisciplinary pain program. The records do not document*

*recently that the patient has any red flags indicating an issue with escalating medication use or would need to be admitted into a program to detox. The report dated September 21, 2009, does not indicate that the patient has exhausted outpatient conservative treatment. According to the referenced guidelines, multidisciplinary programs are only indicated if there is an absence of other options likely to result in significant clinical improvement. The patient has recently participated in a WHP, which reportedly had a psychological component, and it is unclear how the psychological component in the CPMP would be more beneficial than the program the patient recently attended.”*

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

According to the medical records, the patient has undergone primary, secondary and tertiary levels of care in terms of therapy, surgery with injections and finally a WHP which is multidisciplinary with both physical therapy and psych component as well. The patient has been exposed to all facets of a tertiary care program and PMP would represent duplication of services and overutilization. Despite ongoing pain issues after a WHP, the direct referral for a PMP is unnecessary and not supported by ODG.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**