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Notice of Independent Review Decision

DATE OF REVIEW: July 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of chronic pain management program, 80 hours.

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

Member of the American Psychological Association,
Listed in the National Register of HealthService Providers in Psychology,
Member of the International Neuropsychological Society.

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

xxxx:

- Utilization reviews (04/19/10, 05/11/10)

Dr.:

- Office visits (04/01/10 - 04/07/10)

xxxx xxxx:

- Utilization reviews (04/19/10, 05/11/10)
- Office visits (04/04/03 - 05/11/10)

xxxx xxxx xxxx:

- Office visits (10/31/07 - 05/07/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx, while lifting a barrel with a coworker. The coworker apparently let him down resulting in a jerking injury. He injured his left shoulder and neck.

1995 – 2009: Initially, the patient underwent extensive chiropractic therapy with manipulation and rotator cuff surgery in xxxx. On December 4, 1998, he suffered a new injury to his left shoulder, which involved a falling of the hydraulic jack. Dr. placed him at maximum medical improvement (MMI) and assigned 11%

whole person impairment (WPI) rating for the June 13, 2000, injury. The patient was diagnosed with cervical facet arthropathy and was treated with medications and cervical medial branch blocks.

In April 2003, , M.D., noted the patient was status post cervical facet injections with transient relief. The patient had ongoing pain in the neck radiating into the left shoulder and left midthoracic posterior chest wall pain, which seemed to be deep in his left scapula and radiating to the anterior chest. Dr. diagnosed myofascial pain syndrome and left chest wall pain; refilled Vioxx, Norco and Neurontin; issued a prescription for an RS muscle stimulator device and recommended therapy to the cervical region.

Magnetic resonance imaging (MRI) of the thoracic spine revealed early degenerative spondylosis greatest at T9-T10 and early multilevel degenerative thoracic facet joint arthrosis bilaterally.

M.D., diagnosed nonspecific pain complex and probable tension myalgia syndrome of the left shoulder with a history of previous rotator cuff repair and referred the patient to a pain management physician. The patient was then treated with epidural steroid injection (ESI) in 2004 with temporary relief.

In 2006, x-rays of the cervical spine were unremarkable. X-rays of the left shoulder revealed a sclerotic area in the humeral head, which was not seen previously representing probable area of aseptic necrosis. MRI of the left shoulder revealed: (1) Avascular necrosis within the proximal humeral epiphysis. (2) Status post rotator cuff reconstruction and acromioclavicular (AC) decompression. (3) Postsurgical changes versus mild tendinosis. (4) Small glenohumeral joint effusion and small subacromial subdeltoid bursitis.

In October 2007, M.D., performed a designated doctor evaluation (DDE) and believed the extent of injury should be limited to the avascular necrosis in the left shoulder. The patient was able to return to work at full capacity.

In September 2008, a functional capacity evaluation (FCE) placed the patient at a medium physical demand level (PDL) as against heavy PDL requirement of his job.

Electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities failed to demonstrate any form of radiculopathy. MRI of the cervical spine revealed: (1) Broad 2-mm osteophyte disc protrusion complex at C2-C3. (2) Broad 2-mm disc protrusion at C3-C4. (3) Mild left neuroforaminal narrowing at C4-C5 with a broad-based disc protrusion measuring 1 mm to the right and 2 mm to the left of midline. (4) C5-C6 and C7-T1 both demonstrated a broad 1 mm disc bulge.

The patient had gross restriction in range of motion (ROM) and strength of the left upper extremity in general and left shoulder in particular. He underwent a left shoulder humeral head resurfacing and a global metallic cap placement over the excised avascular necrosis of the humeral head on xxxxx. The patient could primarily do only right-handed work and had significant limitations in regards to repetitive reaching. He received therapy and FCE revealed that he was severely disabled.

In April 2009, M.D., a designated doctor, noted the patient continued to have problems with facet joint symptoms from degenerative disc disease (DDD) of the cervical spine. He also had left shoulder pain in which he ultimately developed avascular necrosis requiring a resurfacing arthroplasty. Hence his neck symptoms were unchanged and shoulder symptoms had improved after recent surgery, but he continued to have pain and weakness.

Dr. performed a required medical evaluation (RME) and rendered the following opinions: (1) He had sustained a nonspecific injury to his left shoulder at best which could be a sprain/strain. (2) The probability of his sprain/strain syndrome or even a chronic tendonitis/bursitis to the shoulder could be accepted as associated with the July 1995, incident. (3) Current clinical diagnosis would be status post avascular necrosis with interposition arthroplasty left shoulder with residual ROM deficiencies and complaints of subjective pain. (4) There was absolutely no need for ongoing clinical care associated with the original work-related injury. (5) Medical records did not support the necessity for cyclobenzaprine. He was no longer utilizing Ultram, Lexapro, Zolpidem and Naprosyn. Celebrex was not reasonable and continued utilization of hydrocodone did not appear to be appropriate. (7) Utilization of a transcutaneous electrical nerve stimulation (TENS) unit did not seem to be medically necessary or appropriate to the work-related incident.

2010: In January, M.D., noted worsening of the left arm pain associated with numbness and tingling and inability lifting the left upper extremity. He diagnosed cervical spondylosis versus carpal tunnel and prescribed Neurontin and Darvocet. An EMG/NCV study of the upper extremities revealed mild bilateral median neuropathy across both wrists. X-rays of the cervical spine revealed moderate facet arthrosis with mild-to-moderate disc degeneration at C3-C4, C4-C5 and C5-C6. Dr. added Fentanyl patches and baclofen and submitted request for pre-authorization for cervical rhizotomy. He also discussed treatment options including interdisciplinary pain management program to increase the patient's ability to self manage pain, reduce/eliminate use of ongoing healthcare services and reduce the misuse/overuse on medications.

In April, a physical performance examination (PPE) indicated the patient had failed multiple interventions and was on pain medications to provide relief. The patient qualified at the light PDL. ROM and strength in the left arm were below normal. The evaluator recommended a chronic pain management program (CPMP) to attempt to introduce methods of pain control outside the clinical environment.

In a psychological evaluation, M.A., L.P.C., noted Beck Depression Inventory (BDI) as 36 indicating severe depression and Beck Anxiety Inventory (BAI) as 16 indicating mild anxiety. Ms. diagnosed chronic pain disorder associated with both psychological features and general medical condition and recommended 10 sessions of interdisciplinary CPMP. The rationale for this program included the patient reported sadness, failure and disappointment. He had lost his appetite and reported decreased sleep. He was suffering from chronic pain syndrome and had evidence of loss of function that persisted beyond three months with excessive dependence on healthcare professionals and family. He was experiencing secondary deconditioning due to diffuse and high fear avoidance to

physical activities due to pain level. He had developed psychological sequelae that limited function or recovery after the initial incident including anxiety, fear avoidance, depression and sleep disturbance.

On April 15, 2010, Ph.D., denied the request for 10 sessions of CPMP based on the following rationale: *“The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the program. (1) A negative relationship with the employer/supervisor, high level psychosocial distress (higher pretreatment levels of depression, pain and disability) and increased duration of prereferral disability time. Current testing indicates that this claimant reported having violent ideation. He may fantasize about harming people who make him angry. In some cases, fantasies like these help the individual vent and control his rage, but this ideation could also be a precursor to aggressive behavior. He also endorsed one or more items regarding death anxiety, which could put him in an especially desperate frame of mind. This claimant’s elevated job dissatisfaction, doctor dissatisfaction and family dysfunction scores may suggest that this may be the object of his violent ideation. The claimant appears to have severe psychological issues (anger towards job and physician, violent ideation) and he lacks psychological readiness for a CPMP at this time.”*

On May 11, 2010, Ph.D., denied the appeal for 10 sessions of CPMP based on the following rationale: *“Evidence of aggressive and hostile thinking was identified during the psychological evaluation despite the claimant being uncooperative to psychological testing. He has not been evaluated by clinical psychologist or psychiatrist. Prior to being admitted to a CPMP program it is recommended that he be carefully evaluated to ensure the safety of the staff and treatment team. CPMP treatment can be quite stressful and it is recommended that the claimant’s level of dangerousness be carefully assessed before he is admitted to CPMP treatment. It was also noted that the claimant has not completed all available medical and lower levels of care. He is currently being actively evaluated for various pain management procedures and recently completed additional medical testing. It was unclear if he is still a candidate for additional medical intervention. He had not yet completed lower levels of care including behavioral healthcare despite being injured 15 years ago. Based on these factors, the clinical necessity of a CPMP program is not established at this time.”*

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

The request for 10 sessions of a chronic pain management program was denied because the claimant exhibited numerous factors that would predict a negative outcome in the program. Of particular concern was the severe psychological distress of the claimant including aggressive and hostile ideation. Other negative predictors included an extensive history of disability, 15 years; negative relationship with the employer, fired from the job four months after the injury; no clear evidence of motivation to change. It is recommended by the ODG that many of these issues could be addressed in psychotherapy and referral to psychiatry in an effort to stabilize the claimant’s condition prior to evaluation for a chronic pain management program. There is no indication that individual

psychotherapy was attempted before referral to a chronic pain management program.

As noted in the ODG chapter on chronic pain management:

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or loss of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better-suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain program provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.

The request does not meet the ODG for medical necessity.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES