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Notice of Independent Review Decision

DATE OF REVIEW: May 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 80 hours (10 sessions)

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

Fellow American Academy of Orthopaedic Surgeons

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old male who was standing at the edge of a trench when the trench caved in. He fell into the trench injuring his ankle and lower back on XX/XX/XXXX.

2007: The patient complained of pain in the low back, hip and right leg. X-ray of the lumbar spine revealed disc narrowing at L3-L4 with Schmorl's node deformity of the superior endplate of L4 and spondylosis. X-rays of the pelvis were unremarkable except for degenerative changes at L3-L4 and metallic linear density in the mid pelvis, presumably representing a surgical clip.

Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Degenerative disc space narrowing at L3-L4 with mild disc bulge flattening the ventral thecal sac with minimal left foraminal stenosis. (2) Right lateral disc bulge at L5-S1 impinging on the left L5 nerve root.

Computerized tomography (CT) scan of the abdomen was obtained for abdominal pain. It revealed abnormality involving the anterior/superior endplate of L4

consistent with developmental apophysis, degenerative disc disease (DDD) at L3-L4 and early degenerative changes noted at L2-L3. CT scan of pelvis revealed a few scattered sigmoid diverticula, postoperative changes in the scrotal region and sclerotic lesion involving the posterior aspect of the right sacrum.

In November, M.D., performed a lumbar epidural steroid injection (ESI) at L5-S1 for diagnosis of lumbar herniated nucleus pulposus (HNP) and lumbar radiculopathy.

2010: M.D., an orthopedic surgeon, noted low back pain radiating in to the right hip and right thigh and at times extending to the right foot with a burning character. The patient was not able to receive treatment due to his heart condition. Dr. diagnosed chronic low back pain, lumbar neuritis, lumbar HNP, myofascial pain syndrome and pain in SI joints. He prescribed Valium, Lorcet, Lyrica, Skelaxin, Promethazine and Ambien; recommended transcutaneous electrical nerve stimulation (TENS), lumbar bracing, Therakit, moist hot pad and positioning pillow. MRI of the lumbar spine, nerve conduction velocity (NCV) of the lower extremities and lumbar myelogram followed by CT scan were recommended. Dr. opined the symptoms appeared to have come on as a result of a work related accident and the patient's condition had not reached a medically stationary status. His disability had been extended.

2011: Dr. in a letter of medical necessity stated that the patient had a variety of lower levels of care such as therapy, medication management, injections and various diagnostic studies, which had not resulted in any form of adequate, lasting improvement. The patient continued to complain of pain episodes and was dependent on the continuous use of medications. Hence, Dr. felt it was necessary for the patient to have to have an evaluation for the Functional Restoration Program as he would benefit from such participation as the comprehensive interdisciplinary approach offered the best chances for recovery.

On March 28, 2011, M.D., evaluated the patient for low back pain, depression and poor sleep. Dr. noted that following the injury, the patient attempted return to work but his discomfort was so severe that he was transported to the hospital emergency room (ER) and was treated with morphine. Several treatment recommendations were made but were contraindicated by his cardiac condition. He was treated with Skelaxin, Lyrica and promethazine. Invasive pain management was undertaken by Dr. with temporary relief. The long-term severe pain and the plethora of related problems brought on a depressed mood with features of anxiety, irritability and some anger management issues and deterioration of sleep pattern. Pain assessment revealed low back pain rated at an average of 6-8/10 with medications and up to 9/10 without medications. It was described as a constant aching and occasional throbbing-type of pain with numbness, tingling and paresthesias into the lower extremities. Valsalva maneuvers provoked the back pain and active range of motion (ROM) especially with end range flexion and extension. The patient was utilizing Skelaxin, promethazine, Lyrica, Cymbalta, Plavix, carvedilol, Tricor, Lipitor, ramipril and aspirin. Dr. reviewed MRI of the lumbar spine dated August 6, 2007, that revealed straightening of the lumbar spine, degenerative disc space narrowing at L3-L4 with generalized mild disc bulge flattening the ventral thecal sac, minimal left foraminal stenosis and Schmorl's node at L4 and right lateral disc bulge at L5-S1 impinging on the L5 nerve root with mild facet arthropathy on the right. Review of x-rays revealed metallic linear density in the mid pelvis possibly representing a surgical clip. Review of computerized tomography (CT) scan of the abdomen showed abnormality involving the anterior/superior endplate of L4 consistent with developmental apophysitis, degenerative disc disease (DDD) at L3-L4 and early degenerative changes at L2-L3. Review of x-rays of the lumbar spine revealed disc narrowing at L3-L4 with Schmorl's node deformity of the superior endplate of L4 and spondylosis. Examination revealed depressed mood, flattened affect and antalgic gait with a limp. Examination of the lumbar spine revealed tender spinous

processes, facet joints, multifidus and erector spinae muscles bilaterally with spasms and associated trigger point tenderness. Gluteus maximus and medius and piriformis muscles were tender on the right; ROM was decreased and painful at endpoints; supine straight leg raising (SLR) was positive at 72 degrees on the right and 87 degrees on the left, Kemp's test was positive bilaterally; sensation was decreased to light touch and pinprick in the right great toe. Dr. diagnosed lumbar disc displacement, lumbar radiculopathy, chronic pain syndrome, depressive disorder and sleep disturbance. He recommended behavioral-based functional restoration program to develop stress/coping/pain management skills to enable the patient to decrease his depression/anxiety, help better manage anger and raise comfort levels with improved pain management skills.

Psychological evaluation performed on the same date revealed diagnosis of depression as a result of the consequences of injury. The patient was utilizing Cymbalta for depression since 2008. He scored 28 on Beck Depression Inventory (BDI) consistent with elevated range and 25 on Beck Anxiety Inventory (BAI) consistent with elevated range.

In a physical performance evaluation (PPE) performed on the same day, the patient was found to be a good candidate for participation in a functional restoration/chronic pain management program (CPMP).

Per utilization review dated April 11, 2011, the request for CPMP 80 hours (10 sessions) was denied with following rationale: *"(1) The patient has undergone conservative treatment including lumbar epidural steroid injection (ESI); however, the medical records do not establish that the patient is not a candidate for surgical intervention. There is evidence of a neural compression lesion on imaging, as well as neurologic deficits into the lower extremities on physical examination, thus lumbar decompression may be warranted. As the patient may benefit from lumbar surgery, the requested CPMP would not be medically justified at this time. (2) The records do not establish that the patient currently utilizes narcotic medications, thus multidisciplinary treatment for narcotic drug dependence would not be indicated. (3) As noted in the references, negative predictor of efficacy and completion of function restoration programs include duration of pre-referral disability time and elevated pre-treatment levels of pain. The patient has a prolonged duration of disability at almost 4 years, and his current pain is rated up to 9/10 without medication. Given the presence of these negative predictors of efficacy, it is less likely that a functional restoration program would be of significant benefit for this patient"*.

In a letter of appeal dated April 12, 2011, Dr. stated that the patient's treating physician, who referred this patient for FRP evaluation, was a board certified orthopedic physician and it was his and Dr. opinion that the patient was not a surgical candidate. Dr. opined that the interdisciplinary behaviorally-based functional restoration/CPMP represented his best chance at returning to a higher level of functioning and productivity.

Per reconsideration review dated April 20, 2011, the appeal for 80 hours (10 sessions) of CPMP was denied with the following rationale: *"A lengthy discussion was undertaken with Dr.. The claimant is a xx-year-old who according to an MRI on August 6, 2007, had a right lateral disc bulge at L5-S1 with impingement on the L5 nerve root. The claimant subsequently underwent an L5-S1 epidural steroid injection in November 2007 and had at least transient improvement. Unfortunately, there are no interval records of treatment until 2010 when the claimant was evaluated by Dr.. Dr. at that time recommended a new MRI of the lumbar spine to assess the claimant's complaints. Diagnoses of low back pain with radiculopathy and a pain syndrome were provided. The records, however, do not indicate that the claimant actually received the MRI. Accordingly, it is impossible to know if this claimant has a simple disc protrusion or*

herniation at L5-S1 contributing to the lumbar spine and radicular complaints. More recently, Dr. suggested that the claimant was not a candidate for surgical intervention. However, the rationale for this conclusion is unknown. This conclusion does not appear to have been based on a more recent MRI study. Dr. was unaware whether the recommended new MRI had been performed. Dr. suggested that a pain management program could be initiated to determine whether surgery may be avoided. However, the Official Disability Guidelines state that a program should be initiated only if a goal is to prevent or avoid "controversial or optional surgery". A simple microdiscectomy is hardly a controversial operation for patients that have a straightforward neurocompressive lesion with corresponding symptoms and exam and imaging findings. For this reason, a pain management program would not be recommended for this claimant without further explanation of why the claimant is not a surgical candidate. This would need to include information regarding any recent MRI Imaging of the lumbar spine for this claimant. Dr. agrees that an MRI would be helpful to determine if this claimant has a surgically correctable lesion. It would seem to make much more sense to treat the claimant's underlying problem and eliminate the cause of pain if it is straightforward rather than simply learning how to deal with the pain through a pain management program."

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

THE CLAIMANT IS A XX YEAR OLD MALE WHO SUSTAINED A LOWER BACK INJURY ON XX/XX/XXXX. A SUBSEQUENT MRI SCAN SHOWED A RIGHT-SIDED LATERAL DISC BULGE AT L5-S1 IMPINGING ON THE RIGHT L5 NERVE ROOT. THE CLAIMANT UNDERWENT AN EPIDURAL STEROID INJECTION ON NOVEMBER 6, 2007. THERE IS NO DOCUMENTATION ON THE RESULTS OF THE INJECTION. THE NEXT DOCUMENTATION SUBMITTED IS FROM JAMES KEY, M.D., AN ORTHOPEDIC SURGEON. DR. KEY DOCUMENTS A RIGHT LOWER EXTREMITY RADICULOPATHY FOLLOWING THE L5 NERVE ROOT. DR. KEY AT THAT TIME RECOMMENDED A REPEAT MRI SCAN OF THE LUMBAR SPINE AND ELECTRODIAGNOSTIC STUDY OF THE LOWER EXTREMITIES. THERE IS NO DOCUMENTATION THAT EITHER OF THESE STUDIES HAVE BEEN DONE. THE REQUEST NOW IS FOR A CHRONIC PAIN MANAGEMENT PROGRAM. THIS IN MY OPINION SHOULD BE DENIED. I AGREE WITH THE PREVIOUS REVIEWERS ASSESSMENTS THAT THE CLAIMANT HAS NOT BEEN EXCLUDED FROM HAVING A SURGICAL LESION CAUSING HIS LOWER BACK PAIN WHICH WAS SEEN ON PREVIOUS MRI OF A DISC PROTRUSION AT L5-S1 IMPINGING THE RIGHT L5 NERVE ROOT. THEREFORE PAIN MANAGEMENT IS NOT RECOMMENDED UNTIL THE RESULTS OF THE REPEAT MRI SCAN ARE AVAILABLE TO DETERMINE WHETHER THE PATIENT HAS A SURGICAL LESION OF THE LUMBAR SPINE.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES