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Notice of Independent Review Decision

DATE OF REVIEW: October 11, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799 Chronic Pain Management Program, 80 hours.

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

Fellow American Academy of Physical Medicine and Rehabilitation Member of PASSOR

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 (08/29/11 – 09/15/11)

Direct Medical Healthcare

- Office visits (04/29/10 – 09/08/11)
- Diagnostic studies (03/31/10 – 04/28/11)
- Utilization reviews (01/24/11 – 09/15/11)
- FCE (8/9/11)
- Preauthorization request (09/19/11)

RSL Group

- Office visits (03/31/10 – 08/16/11)
- Diagnostic tests (03/31/10 – 06/28/11)
- PT (03/31/10 – 04/28/11)
- Procedure (04/29/10)
- Reviews (05/07/10 – 02/22/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who strained her hip/buttocks while lifting at work on xx/xx/xxxx.

In February 2008, the patient was seen for low back pain that was made better with Flextra. She was advised to do range of motion (ROM) exercises and apply warm packs. X-rays of the lumbar spine showed mild spondyloarthritic changes.

2010: On Mach 3, 2010, the patient was seen at Medical Center and was diagnosed with lumbar radiculopathy and advised to continue Celebrex.

The patient was then evaluated at Spinal Healthcare where she underwent chiropractic therapy consisting of electrical stimulation, hot packs, mechanical traction and spinal decompression.

At Healthcare, M.D., diagnosed her with lumbosacral strain and right hip strain, prescribed Celebrex and recommended application of heat and massage to the affected areas. X-rays of the lumbar spine showed mild spondyloarthritic changes in the lower lumbar spine with minor levoscoliosis.

Magnetic resonance imaging (MRI) of the lumbar spine showed mild spondylosis at L2-L3, lower lumbar facet arthrosis chiefly affecting the right side at L4-L5 and L5-S1 with associated mild neural foraminal encroachment.

Dr. treated the patient with trazodone, Pristiq, Celebrex for the diagnosis of lumbosacral strain and right hip contusion.

M.D., performed a right trochanteric injection for the diagnosis of trochanteric bursitis. X-rays of the pelvis and the right hip showed some sclerotic changes in the hip joint but well-preserved joint space. Thereafter, Dr. treated the patient with Arthrotec and Vicodin at night for right lower extremity pain starting from the posterolateral hip all the way down to her foot with occasional numbness.

In a peer review, M.D., gave the following opinions: It was not medically probable that the patient sustained any acute structural damage to the lumbar spine on xx/xx/xxxx. There was no acute structural damage to the lumbar spine as related to the xx/xx/xxxx work event. At best the patient had sustained a self-limiting lumbar strain without evidence of objective radiculopathy. The March 31, 2010, report noted the patient stated she had minimal relief with chiropractic treatment. However, per the following from the ODG, the patient should have had complete recovery within four to six weeks of onset. ODG would not support any additional active therapy. Any continuation of Celebrex was not causally related to the work event in all probability. No opioids or muscle relaxants would be reasonable at this time as related to the lumbar strain over eight weeks ago.

MRI of the right hip obtained in May 2010 showed a small subchondral cyst in the right acetabular roof laterally and minimal capsular fluid.

M.D., noted an antalgic gait with a cane and abnormal heel-to-toe walk. He diagnosed neural foraminal stenosis with radicular symptoms and recommended therapy as well as a trial of nerve root blocks at L4 and L5 on the right.

In a designated doctor evaluation (DDE), M.D., opined that the patient's disability was a direct result of the work-related injury from xx/xx/xxxx, to the present. The extent of the patient's injury would be right hip pain and lumbar strain. The hip pain was most likely a direct result of the compensable injury. The patient was not able to return to work.

2011: In a required medical evaluation (RME) M.D., opined the patient was capable of returning to part-time work. The extent of injury was to the right hip, right sacroiliac (SI) joint, lumbar spine, upper medial aspect of the right thigh in the groin area and the lateral aspect of the thigh. She was remarkably tender in the right greater trochanterica area

The patient came under the treatment of D.C., and was provided a lumbar brace.

Dr. prescribed Norco, Zanaflex and Naprosyn and recommended active and passive modalities three times a week for six weeks.

Electrodiagnostic studies obtained in April demonstrated lumbosacral radiculopathy.

M.D., orthopedic surgeon, noted tenderness on palpating the L4, L5, and S1 spinous processes. Heel-and-toe raise was painful, while deep tendon reflexes were 2/4 bilaterally. There was decreased sensation over the L4-L5 dermatomes in the right lower extremity. Straight leg raise (SLR) test was positive bilaterally. Dr. suggested medial branch block targeting the L4-L5 and L5-S1 facet joints on the right.

A videonystagmography showed evidence of significant central vestibular dysfunction.

A behavioral health evaluation was conducted for increasing depression and withdrawal since the injury. The patient was noted to have a history of depression for most of her life and was taking an antidepressant since the early 1990s. She was currently taking Pristiq. The psychologist diagnosed recurrent major depressive disorder and pain disorder. Recommendations included individual psychotherapy to address depression and reported feelings of hopelessness and self-worth, psychiatric assessment and treatment as indicated, and conferring results with referring physician and multidisciplinary treatment team.

A utilization review dated June 14, 2011, denied the request for individual psychotherapy sessions x6. The request was subsequently withdrawn.

A functional capacity evaluation (FCE) placed the patient at a sedentary physical demand level (PDL) versus medium PDL required by her job as a cashier. It was determined that the patient was a good candidate for a pain management program.

On August 11, 2011, the patient attended an orientation session for chronic pain management program (CPMP).

On August 29, 2011, the request for CPMP x80 hours was non-authorized by Ph.D. Rationale: *“The patient is reportedly at a sedentary PDL with a required level of medium. She is noted to have anxiety, depression, and fear avoidance issues. Dr. reported that she still has a job to return to but she has not attempted to return to work. It is not noted that she has attempted to reduce her medications. Her medial diagnoses are noted to be sciatic neuritis and right hip injury. It is not clear based on the available documentation that the patient is an appropriate candidate for a chronic pain management program (CPMP).”*

Dr. requested reconsideration of the denial giving the following explanation: *“First, the patient is not alcohol dependent that was in her family history, but not her. She has not attempted to return to work, because she is still in extreme pain and uses a walker to ambulate. She does fulfill the criteria according to the ODG for chronic pain as is noted in the report by Dr. and the request of our team. We would respectfully request that a reconsideration of this request be performed at this time.”*

On September 15, 2011, the appeal for CPMP x80 hours was denied by M.D. Rationale: *“The patient has diagnosis of psychogenic pain, lumbar radiculitis, and depression. Review of the initial evaluation by Dr. do not specifically address the underlying psychological issues as stated and there is no specific plan presented to deal with these predictors of poor outcome. As such, this case does not meet the criteria in the ODG for chronic pain management program. Recommend denial.”*

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

Documentation available reports concerns of psychological / behavioral diagnosis of major recurrent depression, BiPolar Disorder, Suicidal ideations in the past. There is no appreciation in the documentation regarding extent of past treatment of any psychological condition nor pre-injury psychological condition to compare to the current reported findings of Major Depression. Per ODG Guidelines: “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.” There are no specifics in the documentation regarding these concerns as well.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES