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Notice of Independent Review Decision

DATE OF REVIEW: October 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of chronic pain management program (CPMP)

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

The reviewer is a licensed psychologist in the State of Texas with 33 years of experience in behavioral medicine and the treatment of chronic pain. He is a member of the American Psychological Association, International Neuropsychological Society, and is listed in the National Register of Health Service Providers in Psychology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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 (08/12/11, 09/02/11)
- Office visits (09/22/10 – 06/27/11)
- Procedure (04/25/11)
- Utilization reviews (08/12/11, 09/02/11)
- Office visits (11/09/09 – 07/28/11)
- Procedures (03/30/11, 06/21/11)
- Reviews (11/06/07 – 03/07/11)
- Utilization reviews (12/29/09 – 08/12/11)

Dr.

- Office visits (11/09/09 – 01/10/11)
- Therapy (05/18/11 – 09/21/11)

- Office visits (11/09/09 – 01/10/11)
- Therapy (05/18/11 – 09/21/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was working on xx/xx/xx, when he was lifting crates of antifreeze from a pallet to the floor through a door when he twisted and felt something wrong. The pain worsened and he could not take it anymore.

2007: On November 6, 2007, M.D., performed a designated doctor evaluation (DDE) and noted the following treatment history: *“The patient had magnetic resonance (MRI) of the lumbar spine on November 2, 2005, that revealed right-sided lateral and foraminal protruding disc at L3-L4 with a superior prolapse component to lie behind the L3 vertebra causing asymmetric marked foraminal stenosis on the right and status post left L5-S1 laminectomy and mild hypertrophic facet arthropathy at L4-L5. There was disc desiccation and degenerative spondylosis involved at L2-L3 and L3-L4 greater than the remaining levels.*

From November 2005 through 2006, the patient was diagnosed with lumbar radiculopathy secondary to far lateral disc herniation at L3-L4 and was treated with lumbar epidural steroid injection (ESI) on the right. The patient did not make substantive improvement in the clinical presentation and was recommended discectomy to correct the L3-L4 disc herniation. A lumbar MRI performed on July 20, 2006, revealed a bulge at L3-L4 with superimposed 3-mm right foraminal protrusion causing moderate stenosis and possible right L3 radiculopathy.

D.O., felt the patient might be a candidate for surgical decompression at the L4-L5 and L3-L4 levels. A myelogram and post-myelogram computerized tomography (CT) performed on January 26, 2007, revealed mild degree of left convexity, estimated 10 to 12 degrees mild lumbar scoliosis and degenerative disc disease (DDD) at multiple levels.

On February 13, 2007, Dr. assessed 8% whole person impairment (WPI) rating.

Dr. assessed statutory MMI as of November 2, 2007, with 5% WPI rating.

2008: On January 9, 2008, and independent review organization (IRO) authorized right L3-L4 hemilaminectomy, foraminotomy and discectomy. The following treatment history was noted: *An electromyography/nerve conduction velocity (EMG/NCV) study performed in January 2006 revealed acute and chronic right L4 radiculopathy. In August and September 2006, patient underwent right L4 nerve root blocks with minimal effect and was eventually recommended decompression surgery which was denied because the patient was obese. In April 2007, Dr. noted significant and persistent radicular complaints and recommended right L3-L4 hemilaminectomy, foraminotomy and discectomy. The patient weighed 310 lbs. In November 2007, the requested lumbar surgery was denied with the following rationale: The patient is reportedly 70 inches tall weighing 315 lbs in 2005. It is unclear if the patient has had any*

weight reduction. Prior to surgical intervention, the patient should reduce his body mass index.

2009: In November, the patient was seen at Healthcare Systems for lumbosacral radiculitis and was recommended conservative care. He underwent a physical performance evaluation (PPE) and scored 30 on the Beck Depression Inventory (BDI). The evaluator recommended 10 days of chronic pain management program (CPMP). a psychologist, diagnosed chronic pain disorder associated both psychological features and general medical condition and depressive disorder and recommended interdisciplinary CPMP.

Per utilization review dated December 29, 2009, the request for 10 sessions of CPMP was denied with the following rationale: *“The request was inconsistent with the requirement; an “inadequate and thorough evaluation” was provided and that “negative predictors of success are addressed”. There is no “physical exam that rules out conditions that require treatment prior to initiating the program”. Thus this is not an “adequate and thorough” multidisciplinary evaluation of this patient to determine the appropriateness of a chronic pain management as required by current guidelines. Therefore, a more comprehensive analysis from behavioral and appropriate psychometric perspective would be necessary to demonstrate that he is an appropriate candidate for the program, and is likely to benefit, thus constituting the requisite “adequate and thorough evaluation” of this problem for a CPMP. Furthermore, this is a 4-year-old injury and the etiology and maintenance of the patient’s pain complaints have not been adequately assessed. The request is inconsistent with the requirements that “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”. The “duration” of this injury which is a negative predictor of success is not addressed in the evaluation as required by current guidelines. Based on the documentation provided, ODG criteria were not met. The request for a CPMP x10 is not recommended as reasonable or necessary”.*

2010: From January through December, the patient was evaluated by D.O., for constant backache. History was positive for hypertension, deep vein thrombosis (DVT) and lumbar spine surgery in 2001, Greenfield filter placement secondary to recurrent DVT and left knee replacement. Dr. maintained the patient on medications consisting of hydrocodone, Zanaflex and Celebrex. In December, Dr. recommended CPMP.

From March through August, D.O., an orthopedic surgeon, recommended CPMP which was denied.

2011: In January, the patient underwent a PPE in which he qualified at the medium physical demand level (PDL). He scored 27 on the BDI and 17 on the Beck Anxiety Inventory (BAI) and was recommended 10 sessions of CPMP.

Dr. diagnosed chronic pain disorder associated with both psychological features and general conditions and recommended 10 sessions of work hardening program (WHP). Per utilization review dated February 18, 2011, the request for CPMP was denied.

D.O., evaluated the patient for consideration of laparoscopic band because of morbid obesity. He assessed hypertension, hypercholesterolemia, gallbladder disease, low back pain, joint pain, morbid obesity, obstructive sleep apnea, edema, MRSA, hypertriglyceridemia and clotting defect and recommended cardiac clearance before proceeding with surgery.

M.D., performed a peer review and opined that based on the records provided it was not reasonable to provide the patient with CPMP and the work conditioning/WHP and the use of TENS unit was not supported by ODG. A bilateral lower extremity venous Doppler obtained in March was negative.

M.D., a pain management physician, evaluated the patient for chronic low back and right leg pain. The patient reported constant, throbbing and aching low back pain radiating into the right lower extremity associated with numbness, tingling and weakness of the right leg. Examination showed an antalgic gait with decreased range of motion (ROM). Dr. assessed lumbar IVD, low back pain and lumbar radiculitis and performed an ESI at L3-L4. In April, an IRO upheld the denial for CPMP.

On April 25, 2011, Dr. performed laparoscopic adjustable gastric band, AP standard band and type 2 port for morbid obesity.

On June 21, 2011, Dr. performed the second lumbar ESI and noted 80% pain relief. He recommended home-based therapy to maintain ROM and lumbar strength to avoid deconditioning.

In a repeat PPE dated June 27, 2011, the patient qualified at the light-medium PDL and was recommended 10 days of CPMP.

On July 30, 2011, Dr. recommended 10 days of CPMP and opined that the patient met the minimal requirements for admission into CPMP based on ODG but also the criteria for ACOEM.

Per utilization review dated August 12, 2011, the request for CPMP was denied by Ph.D., with the following rationale: *"I spoke with and discussed the case. reported that the patient has lost weight and this is why the CPMP was denied before. Yet, he remains significantly overweight. She reported that he has had injections since the last request but his status otherwise remains about the same and he has not had other active treatment recently besides injections. The patient is not appropriately identified as a reasonable candidate for CPMP. Chronic pain management has been denied several times and there is not a significant change in barriers to recovery. Based on the available information, the request for chronic pain management is denied per evidence-based guidelines"*.

On August 19, 2011, Dr. appealed for CPMP and opined the patient's obesity had been addressed with gastric banding, increased activity and nutritional counseling and had lost 94 lbs. He was a large-framed man standing 6 feet tall and continued to lose weight and drop clothing sizes down from a 50 inch waist to 44. He opined that 94 lbs was sufficient weight loss to materially alter functional psychological status with a CPMP. He further opined the patient had attempted medications with difficulty and was noted to be allergic to codeine and

could not take tramadol. He also reported stomach irritation with alternate pain medication including hydrocodone and Lodine. The patient continued to experience significant low back pain with radiating symptoms down his right leg and pain increased with activity including ambulation. He continued to present with physical and psychological barriers as a result of his chronic pain and had not had the opportunity to address pain complaints through a multidisciplinary pain program. The patient had exhausted all lower levels of care including injections and individual psychotherapy and met ODG criteria for admission into the CPMP.

Per reconsideration review dated September 2, 2011, the request for CPMP was denied with the following rationale: *“The peer-to-peer review did not reveal any additional information which would warrant overturning the previous non-certification. There is no indication that the patient’s weight loss has been completed or what there are in terms of changes in his functional abilities. While there is an indication that the patient might not be able to return to work and that functional improvement might be the goal for pain management there is no indication of what the actual functional improvement goals would be for the pain management program. Moreover, there is an indication that the patient wishes to be referred for surgery if the pain management program is not approved. All of these together indicate there is still inadequate understanding of this patient and his appropriateness based on full assessment prior to considering a pain management program and adequate planning for a chronic pain management program as specified in the ODG. The current recommendation is to uphold the previous recommendation for non-certification”.*

On September 21, 2011, Dr. noted low back pain and referred the patient for surgical consultation with Dr..

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

THE CLAIMANT WAS INJURED WHILE LIFTING HEAVY OBJECTS 6 YEARS AGO. HE HAD BEEN TREATED WITH PRIMARY AND SECONDARY TREATMENTS FOR HIS CHRONIC PAIN. HE WAS EVALUATED FOR SURGERY AND FOUND THAT A SURGICALLY TREATABLE LESION WAS PRESENT BUT DUE TO HIS OBESITY SURGERY COULD NOT BE PERFORMED. A CHRONIC PAIN MANAGEMENT PROGRAM WAS REQUESTED NUMEROUS TIMES BUT WAS DENIED FOR VARIOUS CLINICAL REASONS. HE RECENTLY UNDERWENT GASTRIC BY-PASS SURGERY AND HAS LOST 95 LBS. FOLLOWING THE SIGNIFICANT WEIGHT LOSS HE WAS ONCE AGAIN REFERRED FOR A CHRONIC PAIN MANAGEMENT PROGRAM. BUT AS NOTED IN THE RECORDS, DR. REFERRED HIM TO DR. FOR A SURGICAL EVALUATION.

In the Chapter on the treatment of chronic pain in the ODG it is noted:
ODG criteria for the general use of multidisciplinary pain management programs:
Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made.
- (2) Previous methods of treating the chronic pain have been unsuccessful.
- (3) The patient has a significant loss of ability to function independently resulting from

the chronic pain.

(3) The patient is not a candidate where surgery would clearly be warranted.

(5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

Based on the documentation provided the issue regarding surgical treatment of the claimant's injury has yet to be resolved. Clinically, if the claimant believes that a surgical solution is available for his chronic pain then a functional restoration program cannot be effective. The request for 10 sessions of a chronic pain management program does not meet the ODG for medical necessity until the claimant's surgical candidacy is resolved.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES