

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: September 12, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Multidisciplinary 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

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.

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained injury to her back on xx/xx/xx, when she fell from a rolling office chair.

2010: Magnetic resonance imaging (MRI) of the cervical spine performed on December 20, 2010, revealed cervical lordosis straightening suggestive of muscular pain or spasm; 2-3 mm left paracentral disc substance protrusion/herniations at C2-C3, C4-C5 and C5-C6 possibly contacting or minimally indenting the spinal cord; and left paracentral annular tear and 3-4 mm discal substance protrusion/herniation at C3-C4 mildly to moderately indenting the thecal sac and a mild degree of central stenosis. MRI of the lumbar spine performed on same date revealed 2-3 mm right paracentral discal substance protrusion/herniation at L5-S1 minimally indenting the thecal sac. EMG/NCV of upper and lower extremities performed the next day, revealed a prolonged sensory latency with stimulation of both sural nerves indicating probable trauma or entrapment of both sural nerves at the ankle. Prolonged sensory latency with stimulation of both radial nerves and the right median nerve indicating probable trauma or entrapment of these three nerves at the wrist and prolonged left median motor latency indicating probable trauma or entrapment of the left median nerve at the wrist. The slowing in the left ulnar nerve as it crossed over

the medial epicondyle indicated probable trauma or entrapment of this nerve at the elbow. The evaluator opined multiple traumatic or entrapment neuropathies, possibilities of diabetes should be considered.

2011: A repeat MRI of the cervical spine revealed: (1) Reversal of normal lordotic curvature. (2) 3-mm posterocentral disc protrusion at C3-C4 indenting the thecal sac. The protruded disc approximated the subarachnoid space. Central spinal canal stenosis, bilateral uncovertebral hypertrophic changes and mild bilateral foraminal stenosis. (3) Disc desiccation at C4-C5 with 2-mm posterocentral disc bulge. (4) Loss of disc height at C5-C6 with anterior spondylosis and 3-mm left paracentral broad based disc bulge. Uncovertebral hypertrophic change and left foraminal stenosis and central spinal stenosis.

In March, the patient was evaluated at Accuhealth IMC by M.D., for complaints of neck and lower back pain with radiculopathy of the upper and lower extremities bilaterally and pain and tenderness of the thoracic spine. The patient had one lumbar epidural steroid injection (ESI). Dr. recommended physical therapy (PT).

M.D., performed cervical and pelvic-lumbar scans that revealed an inflammatory reaction at the cervical spine facet joint margins. Findings consistent with a strain/sprain of the cervical spine, sonographic evidence demonstrating an early form of degenerative joint disease of the cervical spine, slight to moderate amount of swelling demonstrated sonographically about the erector spinae muscle and concurrent compartment of the scanned area of the lumbar spine, sonographic indication of joint inflammation demonstrated by increased reflection signals at the lumbar joint planes bilaterally L2 and L5 and evidence of early form of degenerative osteoarthritis of the lumbar spine.

M.D., a pain management physician, evaluated the patient for pain in the lower back and neck rated at 4-8/10. The patient was utilizing Zanaflex and Neurontin. Examination findings were unchanged from the previous exam. Dr. assessed fair pain control with current regimen and recommended orthopedic consultation and recommended continuing medications. He recommended follow-up in eight weeks.

In May, Ph.D., performed the behavioral medicine evaluation and noted following treatment history: *The patient was treated with pain medications and had undergone epidural steroid injection and PT. She had worsening of symptoms following the ESI and PT. In an initial examination and consultation dated March 22, 2011, Dr. diagnosed thoracic and lumbosacral radiculitis, sacroiliac joint dysfunction, lumbar disc displacement and cervical disc protrusion and recommended x-rays, previous records, physical performance examination, PT evaluation and PT. The patient had undergone four sessions of health and behavioral interventions in April through May. She benefited from these sessions and had reduction of average pain levels from 8 down to 6, reduction of emotional symptoms, reduction of beck depression inventory II (BDI II) score from 12 down to 9 and beck anxiety inventory (BAI) score from 15 down to 12. In May, M.D., an orthopedic surgeon, diagnosed lumbar syndrome with distinct radicular pattern, possible SI dysfunction and pain behavior and opined that surgical intervention was not necessary and it appeared that the patient may need some help with pain control issues. Dr. noted that the request for PT was denied. On follow-up dated May 2011, Dr. noted persistent debilitating pain and*

had exhausted all conservative treatment options including pain medication, x-rays, MRI scan, EMG testing, ESI, individual cognitive behavioral therapy, orthopedic consultation which ruled out surgical intervention, PT and home exercise program without sufficient functional gains. Dr. recommended a psychological evaluation to determine if the patient would be appropriate for the trial of interdisciplinary chronic pain management program (CPMP) at the levels determinate any other treatment needs. The patient was utilizing Tylenol #2, gabapentin, Flexeril and Elavil. History was positive for right hand surgery in 1999 as well as left surgical carpal tunnel release in 2001 with excellent outcome. Work related repetitive stress injury in xx/xx including bilateral carpal tunnel syndrome (CTS) as well as shoulder impingement syndrome. The patient scored 9 on BDI consistent with minimal range of depressive symptoms and 12 on BAI consistent with mild range of anxiety symptoms including severe inability to relax. Dr. opined that the patient was at risk for a pattern of worsening disability unless self perceptions of disability would be eradicated and pain management as well as problem solving skills were improved. She appeared to have benefited from individual counseling as evidence by initial acquisition of pain coping skills. He diagnosed pain disorder associated with both psychological factors and a general medical condition and adjustment disorder with anxiety and recommended two weeks of interdisciplinary pain management program five days a week eight hours a day for 10 days.

In a functional capacity evaluation (FCE) the patient qualified at sedentary physical demand level (PDL). The evaluator opined that the limiting factors included continuing pain/weakness, fear avoidance observed inhibition, poor positional tolerance, deficits in ROM/strength and physical deconditioning due to lack of regular exercise. He recommended a chronic pain management program to work on general condition and pain management techniques for a more functional level.

Per utilization review dated July 7, 2011, the request for multidisciplinary chronic pain management program (80 hours) was denied with following rational: *"The request for chronic pain management program is not indicated. The claimant has high psychological stressors or fear of avoidance or physical activity. The claimant was only working as a and but is capable of returning to a rehabilitation program to pursue a nursing degree. The claimant has high fear of avoidance which is negative predictor of success. Peer review guidelines indicate that negative predictors of success and failure must be identified and screened with specified plan prior to chronic pain management program. The claimant documents poor adjustment and negative outlook about future employment and had high elevated psychological stressors of fear avoidance. Therefore as this claimant stressors over current employment and is not currently not working and has not intentions or returning to his previous position and is wanting to pursue a higher physical level job through job retraining. The chronic pain management program is not medically indicated or supported."*

On July 22, 2011, Dr. appealed for the chronic pain management program. He opined: *"The patient would benefit significantly from participation in an interdisciplinary chronic pain management program to improve pain coping skills and reduce fear as well as avoidance of activity. She requires an interdisciplinary chronic pan management program in order to achieve the goal of successfully returning to work without further difficulty or incident. The*

recommended treatment will increase her emotional, social, and occupational functioning to a more optimal level and facilitate appropriate recommendations for further treatment, if necessary to reduce emotional symptoms and functional impairment.”

On August 1, 2011, the appeal was denied. Rationale: Physical evaluation showed Jackson compression. FCE on June 20, 2011, noted a sedentary physical demand level. Behavioral medicinal evaluation on May 26, 2011, notes her BDI-II score was 9 and her BAI score 12 both in minimal and mild ranges. Dr. also notes the claimant shows desire to return to work. The history and documentation provided do not objectively support the request for multidisciplinary chronic pain management program (80 hours). FCE on June 20, 2011, shows sedentary physical demand level, but the patient’s occupation is a which has minimal PDL requirements. The patient is also on minimal analgesics (Tylenol #2 BID). Based on this information the request is not supported for the level of care of CPMP. The medical records provided failed to establish medical necessity therefore the request for multidisciplinary CPMP (80 hours) is non-certified.

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

Medical records indicate a BDI – II score of 9 and a BAI of 12, both mild, and Tylenol #2, which is minimal. The prior occupation was as a, which would be minimal PDL and an FCE revealed she was capable of performing a sedentary physical demand level. Therefore, the medical records do not support the medical necessity for a multidisciplinary CPMP

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**