

# MATUTECH, INC.

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

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## Notice of Independent Review Decision

**DATE OF REVIEW: APRIL 9, 2012**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program 80 hours/unit outpatient.

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

International Neuropsychological Society  
American Psychological Association

**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**

- Utilization reviews (02/13/12 – 03/19/12)
- PPE (12/15/11 – 01/17/12)
- Office visits (02/07/12 – 02/22/12)
- Utilization reviews (02/13/12 – 03/19/12)
- ER visit (07/30/10)
- Office visits (08/02/10 – 03/14/12)
- Diagnostics (07/30/10 – 01/10/12)
- Operative notes (03/23/11 – 01/02/12)
- Therapy, WHP and CPMP (09/29/10 – 01/25/12)
- Reviews (12/06/10 – 08/08/11)
- Utilization reviews (02/13/12 – 03/19/12)

**ODG has been utilized for the denials.**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who had her left hand crushed in a machine on xx/xx/xx. The machine had some sort of nails that perforated her dorsal wrist and carpal area.

**2010:** From July through December the patient was evaluated at by an orthopedic surgeon, a neurologist and a hand and microsurgeon. At ER she underwent x-rays and was diagnosed with fracture of distal fifth metacarpal, tiny avulsion fracture along the ulnar portion of the base of the distal phalanx of the left fourth finger and underwent laceration repair and was placed in a splint. Later, removed sutures and noted the patient was doing well and recommended therapy. From September through October, the patient attended ten sessions of therapy.

evaluated the patient for left hand, left forearm and left axilla pain and diagnosed crushing injury of hand and causalgia of upper limb and ordered magnetic resonance imaging (MRI). obtained electromyography/nerve conduction velocity (EMG/NCV) of the left upper extremity that showed no evidence of either generalized and/or focal peripheral nerve entrapment. assessed posttraumatic crush injury with classic picture of complex regional pain syndrome (CRPS). MRI of the left hand showed grade I tenosynovitis of the extensor digitorum profundi of the second, third and fourth fingers with fluid in the tendon sheath extending from the mild hand distally over a length of 3 cm.

In December performed a designated doctor evaluation (DDE). He assessed maximum medical improvement (MMI) with 9% whole person impairment (WPI) rating. obtained functional capacity evaluation (FCE) that showed the patient was unable to return to work. opined the patient would return to work with restrictions. evaluated the patient for left hand pain. He recommended medical pain management intervention as well as therapy for regaining range of motion and strength. requested for aggressive physical therapy for CRPS.

**2011:** From January through December, the patient was evaluated by. She complained of constant moderately severe restricted movement and stiffness as well as excruciating pain in the left hand area. She was diagnosed with crushing injury of hand, reflex sympathetic dystrophy of the upper limb, fracture of the left small finger metacarpal fracture and proximal phalanx of the left ring finger healed by secondary intension, CRPS, osteoporosis form non use and ankylosis of the left small and ring fingers with significant loss of range of motion to the index and middle finger, untreated fracture of the left small finger with residual malrotation, pain disorder associated with both physiological factors and the medical condition which appeared chronic and depression and dysfunction. The patient was treatment with medications, cervical ganglion blocks, capsulotomy of the metacarpal, phalangeal joints extension, contracture at the top of height ring and small fingers and tenolysis of superficialis and profundus tendons and extensor tendons to the left index, middle, ring, and small fingers and correction of malrotation of left small finger with osteotomy and open reduction internal fixation of the osteotomy site. Postoperatively the patient underwent physical

therapy (PT), work hardening program (WHP) and was recommended chronic pain management program (CPMP).

**2012:** On January 2, 2012, performed cervical ganglion block. In January the patient attended ten days of CPMP. maintained the patient on gabapentin, Motrin and hydrocodone. recommended continuing home exercise program (HEP). In a physical performance evaluation (PPE) the evaluator noted the patient was unable to perform her regular job duties and recommended continuing participation in the CPMP to address mental and psychological issues that were complicating progress in the treatment program.

On February 7, 2012, request for an additional CPMP was submitted. The evaluator opined that due to the intensive nature of the program the patient reported increase in anxiety and sleep disturbance as ODG says "patient's may get worse before they get better" and in addition, she noted reductions in irritability, frustration and BDI depression score. Her subjective pain, muscle tension/spasm depression and forgetfulness had been maintained. The psychological evaluation showed increased in beck anxiety inventory score from 16 to 19 and decreased deck depression inventory from 23 to 17. The patient's previous and current physical demand level (PDL) was sedentary and required PDL was light-medium. The evaluator recommended for authorization for 80 hours/unit day in a CPMP for lasting management of her pain symptoms and related psychosocial problems, as it is was recommended treatment of choice for patient with chronic pain syndrome.

Per utilization review dated February 13, 2012, a request for CPMP for times 80 hours was denied with the followed rationale *"As per report dated February 7, 2012, the patient was seen for evaluation regarding her continued participation in CPMP. It was noted that prior treatment modalities has failed to stabilized the patient's psychosocial distress, increase her engagement in activities of daily living, or enhance physical functioning such that she could safely return to work. The patient was noted to have developed chronic pain syndrome. This is a request for additional 80 hours of CPMP. It was noted that the patient has apparently almost completed ten sessions of CPMP however, there was no clinical documentation provided from the requesting provider regarding a recent patient assessment or otherwise addressing detailing necessity of the proposed services. As per report dated February 7, 2012, it was noted that the patient's pain levels prior to beginning of the program was maintained at same levels. Although the beck depression inventory decreased, the beck anxiety inventory increased moderately. The patient's functional capacity was noted to increase form sedentary to light physical demand level. At the same there was also no objective documentation of the decreased need for medications intake after the initial program. An updated post program treatment with defined goals and planned duration was also not included for review. As such, the medical necessity of the proposed service has not been substantiated"*.

On follow-up refill Norco and Neurontin and recommended completing course of CPMP.

In appeal letter dated February 22, 2012, the evaluator opined that there was 35% improvement in the right hand grip testing and rapid exchange grip was improvement by 25%. The patient's PDL remained sedentary and required PDL was light to medium. He recommended authorization for 80 hours/units day in a CPMP. recommended continue active care.

On March 19, 2012, the appeal for 80 hours of CPMP was denied with the following rationale *"The patient currently complains of left hand pain. She participated in 80 hours CPMP with noted improvement. This is an appeal of the request for additional CPMP for 80 hours. It was noted that the previous request was noncertified due to the lack of the lack of a recent patient assessment that addresses the necessity of additional services requested. There was likewise no noted decrease in medication intake after the initial program and updated program goals were not included for review. Updated documentation included integrative summary reports stating the patient's overall progress functionally, vocationally and psychologically. However, other foregoing issues were still not addressed. There is still no mention of any details as to whether the patient had been weaned off or has decreased the intake of her present medications. It is unclear to whether reduction of medication intake has been initiated and as to what stage has the patient been progressing. Furthermore, serial reports from different components of the program containing a detailed progress assessment with objective measures and stage of treatment was not submitted for review. Evidence of patient compliance was likewise not provided. In addition, the updated goals of therapy that is specifically tailored to target the patient's present deficits were not included. I discussed the case with. He stated the patient improved PDL from low sedentary to high sedentary and needs to be at light medium. Medications have decreased I use form ibuprofen 800 mg t.i.d. to q.d. p.r.n. and Vicodin 5/500 mg from t.i.d. to b.i.d. with a plan to wean in 10 days to p.r.n, then cessation. Patient has improved mood and increased sleep from 5 hours to 6-7 hours and is motivated and compliant. She plans to change vocations form a packer to child care. Patient is right hand dominant. Patient seen at q month by. Requested last office visit to be faxed. However, no additional documentation was received at this time. With all of the above factors considered the medical necessity of the above request has not been established and the previous non-certification is upheld"*

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

THE CLAIMANT SUFFERED A CRUSH INJURY TO HER HAND ON XX/XX/XX. SHE WAS TREATED FROM PRIMARY TO TERTIARY CARE. SHE ALMOST COMPLETED 10 SESSIONS OF A CHRONIC PAIN MANAGEMENT PROGRAM, WHEN 10 ADDITIONAL SESSIONS OF THE PROGRAM WERE REQUESTED. THE INITIAL REVIEW RECOMMENDED NON-AUTHORIZATION OF CONTINUATION OF THE PROGRAM AS MEDICALLY NECESSARY BECAUSE THE PROGRESS MADE IN THE FIRST 10 SESSIONS DID NOT JUSTIFY CONTINUATION DUE TO A LACK OF SUFFICIENT PROGRESS. A REQUEST FOR RECONSIDERATION WAS ALSO DENIED WITH ESSENTIALLY THE SAME REASONING THAT

**PROGRESS MADE IN THE FIRST 10 SESSIONS DID NOT JUSTIFY CONTINUATION AND THERE WAS NO MODIFICATION OF THE TREATMENT PLAN THAT WOULD SUGGEST THAT SIGNIFICANT PROGRESS WOULD BE MADE WITH CONTINUATION.**

From the ODG chapter on the treatment of chronic pain: (10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

The documentation provided with the request for services, particularly the "SUMMARY OF PSYCHOLOGICAL EVALUATION RESULTS" AND THE PHYSICAL THERAPY REEVALUATION RESULTS, report minimal progress on both objective and subjective functional measures. No change is noted in medication usage, subjective pain levels, measures of stamina, endurance and functional activities at home. None of the reported levels of performance after 10 sessions of the program would suggest improvement to a mid-point of the end of therapy goals as stipulated by the pain management program. The fact that no other treatments have worked previously would not justify continuation of this treatment, which is also not working. The progress made after 10 sessions of the program would not meet the ODG for the medical necessity of continuation of the program.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**