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Notice of Independent Review Decision

**August 1, 2012**

**IRO CASE #:**

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

Multidisciplinary Chronic Pain Management Program

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

Board Certified 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.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**TDI**

- Utilization reviews (05/11/12, 06/05/12)

**M.D.**

- Office visits (11/27/10 - 06/25/12)
- Diagnostic (11/27/10)
- Procedures (07/07/11, 12/18/10)

**M.D.**

- Diagnostics (07/15/11 - 05/01/12)
- Office visits (01/20/12 - 05/29/12)
- FCE (05/01/12)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who on xx/xx/xx, slipped on wet concrete, fell backward, and landed on her back with her left arm bent under her. She also hit her head on the ground when she fell and was down for a few minutes and was dazed and shaking.

Following the injury, M.D., evaluated the patient for complaints of left wrist pain and swelling. The patient had fusiform swelling around the distal radius. X-rays of the left wrist showed comminuted distal radial fracture with angulation and intra-articular extension and mild displacement.

Dr. performed a reduction maneuver and placed her wrist in a well-formed sugar tong splint. The patient was provided narcotic prescription and recommendation to use sling and no use of the left hand.

In December, the patient was evaluated by M.D., for left wrist pain, some tingling in her fingertips and difficulty with her activities of daily living (ADL). She had tenderness over the distal radius and decreased motion and strength. Dr. obtained x-rays of the left wrist which showed dorsally translated and angulated fracture of the distal radius and intra-articular fracture. He assessed an unstable left distal radius fracture with displacement.

On December 8, 2010, Dr. performed open reduction internal fixation (ORIF) of the left distal radius fracture with three fragments through volar approach.

Postoperatively, the patient was doing well. She was placed into an appropriately padded short-arm cast. Dr. instructed on cast care and placed the patient off work.

On follow-up, the patient was placed into a volar splint for support and protection. She was placed on light duty.

**2011:** From January through December, the patient was under the care of Dr. She had stiffness, decreased strength and tenderness over the distal radius. She was attending therapy and was recommended activities as tolerated.

In June, Dr. noted the patient was fired from the job. She had tenderness in the dorsal and volar aspect of the left wrist. He assessed distal radius fracture (Colles) and complication peculiar to certain specified procedure, mechanical complication of internal orthopedic device, implant and graft, dislocation of prosthetic joint.

On June 29, 2011, Dr. performed removal of deep hardware of the left wrist, as the patient had persistent discomfort related to the left wrist.

On postoperative follow-up, Dr. refilled hydrocodone and recommended therapy.

In July, magnetic resonance imaging (MRI) of the left hand showed the following findings: (1) The distal radius was seen in limited fashion. (2) There were changes consistent with prior surgery with placement and subsequent removal of the plate and screw assembly. (3) There was some residual micro-metallic debris adjacent to the distal radius.

In August, the patient reported ongoing left wrist pain. Examination of the left wrist showed decreased ROM and grip strength, some tenderness dorsally over the distal radius and a well-healed volar incision. X-rays of the left wrist showed healed distal radius fracture with slight ulnar positive variance. Dr. recommended continuing with her therapy program.

Electromyography/nerve conduction velocity study (EMG/NCV) of the upper extremities was unremarkable.

In October, Dr. noted that the patient had diffuse pain through the left wrist and pain located dorsally near the distal ulna. The patient reported volar pain radiating towards the elbow. The patient had increased pain with passive hyperextension of the wrist and decreased grip strength. X-rays of the left wrist showed healed distal radius fracture and a 2-mm ulnar positive variance and 5 degrees volar tilt. Dr. assessed ulnar impaction syndrome of the left wrist. He administered injection of Kenalog in the distal radial ulnar joint which provided 50% pain relief.

On follow-up, the patient reported pain on the radial aspect of the wrist and lateral elbow. Dr. assessed left elbow lateral epicondylitis and left wrist de Quervain's tenosynovitis. He administered a steroid injection in the left wrist and left lateral elbow. The patient reported progress and was placed on light duty with no use of left arm.

**2012:** In January, M.D., evaluated the patient for throbbing left wrist pain radiating to the shoulder and constant achy pain and headaches, neck pain, low back and left shoulder pain. The patient reported feeling frustrated. Dr. assessed left distal radius/ulna fracture, status post surgery and hardware removal. He noted that the patient had completed 12 sessions of PT, four sessions of individual therapy. She was utilizing etodolac. Request for chronic pain management was denied in December 2011.

The patient had physical assessment evaluation at Accuhealth. Treatment recommendations were PT to cervical and lumbar area three times a week for four weeks and home exercise program (HEP).

In February and March, Dr. noted that the patient had psychological evaluation in January and the evaluator had recommended six sessions of individual therapy.

On March 12, 2012, Dr. evaluated the patient for pain on the lateral aspect of the left elbow and the radial styloid. Examination of the left wrist revealed moderate tenderness over the first dorsal wrist compartment, positive Finkelstein's test, decreased ROM and decreased grip strength. Examination of the left elbow revealed moderate tenderness over the lateral epicondyle and increase in pain with forced wrist extension against resistance. Dr. diagnosed complications peculiar to certain specified procedures, mechanical complication of internal

orthopedic device, implant and graft, unspecified mechanical complication of internal orthopedic device, implant and graft, status post hardware removal left distal radius; healed left distal radius fracture; left sprains and strains of wrist, left wrist ulnar impaction syndrome; left elbow lateral epicondylitis and left wrist de Quervain's tenosynovitis. He administered left lateral epicondyle and left first dorsal compartment injection and recommended application of ice to the injected areas.

Dr. noted that the patient had completed 12 sessions of PT and four sessions of individual therapy. The patient had undergone psych evaluation and was recommended six sessions of IT which were approved. He recommended etodolac.

On April 24, 2012, the patient underwent behavioral medicine evaluation. She scored 20 on Beck Depression Inventory (BDI) which was consistent with moderate range of depressive symptoms and 26 on Beck Anxiety Inventory (BAI) consistent with moderate-to-severe range of anxiety symptoms. The evaluator diagnosed pain disorder associated with both psychological factors and a general medical condition and adjustment disorder with mixed anxiety and depressed mood. He recommended two weeks of interdisciplinary pain management program.

On follow-up, Dr. noted constant, pulsing pain in the left hand and wrist, low back pain, neck pain and wrist pain radiating to the neck and shoulder. He recommended continuing etodolac and home exercise program (HEP).

In an FCE dated May 1, 2012, the patient qualified at a sedentary physical demand level (PDL). The evaluator opined that the patient was unable to perform her regular job and recommended CPMP.

Per utilization review dated May 11, 2012, the request for CPMP was denied with the following rationale: *"It is unclear how this injury could have led to such widespread physical and psychological problems. This is not explained. The scope of the weakness suggests somatization disorder or malingering. Neither condition is likely to respond to chronic pain management program. An independent medical examination would be appropriate given the patient's complaints and widespread, severe weakness. The medical necessity of this request is unsupported by the records. This conclusion is consistent with Official Disability Guidelines (chapter on pain) and clinical judgment."*

In an appeal letter dated May 29, 2012, Ph.D., stated that the patient had no motivation to feign injury given that she was ineligible for disability payments sufficient to cover her family's expenses and felt despondent regarding her inability to return to work. Dr. opined that the patient would benefit significantly from participation in an interdisciplinary chronic pain management program (CPMP) to improve pain-coping skills and reduce fear as well as avoidance of activity. She required an interdisciplinary CPMP in order to achieve the goal of

successfully returning to work without further difficulty or incident. The recommended treatment would increase her emotional, social and occupational functioning to a more optimal level and facilitate appropriate recommendation for further treatment, if necessary to reduce emotional symptoms and functional impairment.

Per reconsideration review dated June 5, 2012, the appeal for CPMP was denied with the following rationale: *“Based on the medical records provided and telephone consultation with the AP, 80 hours chronic pain management program are not appropriate or medically necessary. This is a reconsideration of a previous denial of service. During the previous denial questions regarding “somatization disorder and malingering” were raised. While the reconsideration denies any occurrence of malingering, there is no data in support of such a rebuttal. None of the psychological tests administered have specific validity scales to point out any incident of symptom magnification, somatization, or fake bad response style. The tests administered have low specificity and sensitivity. In addition, this program is not CARF accredited and no evidence of was submitted that the program has known positive functional outcomes as required by ODG.”*

In June, Dr. noted ongoing left elbow and wrist pain. The patient reported that the injection on March 12, 2012, had helped some. On June 25, 2012, Dr. noted ulnar impaction. He administered DRUJ steroid injection.

On July 12, 2012, Dr. noted that the patient’s MMPI-2 profile peak score on the Hy scale occurred with relatively high frequency in chronic pain samples. Keller and Butcher (1991) reported that 43% of women in chronic pain samples produce this high-point score. He requested review by an IRO for CPMP five times per week for two weeks.

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

Records indicate the individual has participated in physical therapy, psychotherapy, prescribed medications and there have been suggestions of malingering. In addition, the facility is not CARF certified and no evidence was submitted that the program has known positive functional outcomes as required by ODG. Therefore, the decision for denial is upheld based on the records and ODG.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**