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Notice of Independent Review Decision

DATE OF REVIEW: February 17, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional pain management program five days a week for two weeks, 40 hours, lumbar spine

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

American Board of Family Practice

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

- Diagnostics (02/01/10 - 11/17/10)
- Office visits (06/09/10 - 12/14/11)
- Notice of independent review decision (09/14/11)
- Pre-auth request (12/05/11)

- Utilization reviews (01/04/12 – 01/19/12)

- Pre-auth request letters (01/10/11 – 12/30/11)
- Office visits (08/26/11 – 11/08/11)
- Utilization reviews (01/04/12 – 01/19/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his lower back on xx/xx/xx, when he attempted to loosen a large metal sliding door that had become jammed.

2010: On February 1, 2010, magnetic resonance imaging (MRI) of the lumbar spine was obtained for low back pain and right lower extremity radiculopathy. The study showed: (1) At L2-L3 level, some minimal bulging of the disc into the inferior aspect of the neural foramina with minimal narrowing. (2) At L3-L4, a mild broad-based disc bulge slightly asymmetric in the right paramedian location without focal disc protrusion, mild central spinal narrowing, mild right neural foraminal stenosis and mild/moderate left neural foraminal stenosis. (3) At L4-L5, a broad-based disc bulge without focal disc protrusion, some mild central spinal narrowing, mild right neural foraminal stenosis and moderate left neural foraminal stenosis. (4) At L3-L4 and L4-L5 levels, component of disc osteophyte complexes which encroached upon the neural foramina. (5) At L5-S1, a broad-based disc bulge with a moderate-sized focal central disc protrusion. Increased T2 signals at the posterior margin of the disc at this level were consistent with annular tear. This resulted in encroachment upon the ventral aspect of the thecal sac and overall some mild central spinal line narrowing. Moderate bilateral neural foraminal stenosis was also noted at L5-S1.

On June 9, 2010, a neurosurgeon, evaluated the patient for complaints of leg pain. The patient reported sharp and shooting pain in the right anterior thigh with occasional numbness. The patient had undergone physical therapy (PT) in the past which did not help and the pain was worsened with increased lifting and increased activity. Examination showed diminished patellar reflex and positive straight leg raising (SLR) test on the right. reviewed the MRI findings, prescribed Norco and ibuprofen and recommended a lumbar epidural steroid injection (ESI) to decrease the inflammation within the nerve and possibly relieve patient's radiculopathy.

In July performed a right-sided L3-L4 ESI which was found to be helpful. He noted some decreased sensation in the right posterior calf and slightly diminished patellar reflex on the right. He again recommended a right-sided L5-S1 ESI.

In September, noted that the patient had undergone a trial of three ESIs which were marginally helpful. Examination showed positive SLR test on the right. diagnosed degenerative disc disease (DDD) at L5-S1 as well as a right-sided lower extremity radiculopathy most consistent with S1 and recommended an electromyography (EMG) and a consultation with for second opinion. In October, noted that the ESI and PT had not significantly altered patient's condition. The patient reported that he had three injuries at work. The first one involved a metal slab getting caught on his glove and twisting him; the second was a slip where he caught himself in an awkward position and the third occurred when he was pushing a door.

On October 25, 2010, performed L5-S1 fusion. Postoperatively, the patient reported that the back pain had plateaued and was improving. noted negative SLR test bilaterally. prescribed Norco and Ambien and recommended a follow-up in approximately two months.

2011: On January 19, 2011, x-rays of the lumbar spine showed mild progression of DDD with loss of disc height present at L4-L5.

From January through June, treated the patient with pain medications. He recommended a pain management consultation with.

In July, noted that the patient was experiencing pressure pain in the lumbar back with radiating pain into the right leg. The patient reported that he had attempted to work but had not passed his exam. prescribed hydrocodone and recommended a EMG/nerve conduction velocity (NCV) and a consultation with for chronic pain management.

In August, noted that the patient had been experiencing some psychological distress manifested by mild anxiety regarding his ability to work and financial stressors. recommended pain management program. He opined that the emphasis would be on physical rehabilitation, patient teaching and job stimulation activities with goal of reaching a physical demand level (PDL) of light-medium.

From August 2011 through October 2011 treated the patient with ibuprofen, hydrocodone and trazodone.

performed a psychological evaluation and noted that the patient was experiencing a very significant level of emotional distress, from moderate to the severe range. The psychological testing indicated that the patient's difficulties were primarily emotional problems and not primarily chronic pain syndrome problems. opined the patient's mental health problems should be sorted prior to the chronic pain management program (CPMP). From October 2011, through November 8, 2011 the patient attended six counseling sessions with.

In the interim, performed an EMG study of the lower extremities which revealed evidence of mild-moderate chronic denervation patterns occurring in the right lower lumbar paraspinal muscle region, evidence of mild-moderate chronic denervation patterns as well as some reinnervation in the L5-S1 innervated muscles of the right lower extremity. The findings were consistent with an L5-S1 radiculopathy occurring on the right side of mild-to-moderate severity.

On September 14, 2011, IRO denied the request for CPMP based on the following rationale: *"There are questions concerning whether the patient might be experiencing hardware-type pain for which additional surgery might be required. Lacking a lower level of therapeutic care for the patient's symptoms and with the question of possible need for additional surgery, the request for initial CPMP was not supported by the Official Disability Guidelines (ODG).*

On October 25, 2011, performed L5-S1 laminectomy, discectomy and interbody fusion. Postoperatively, he prescribed hydrocodone and Neurontin.

In November, treated the patient with hydrocodone, trazodone and ibuprofen.

On December 2, 2011, Dr. noted that the patient had participated in pain management program for 10 days making good progress. He recommended continuing participation in the pain management program for 10 more days in order to enhance the process of recovery he had begun.

On December 14, 2011, noted that the patient was feeling markedly better regarding the leg pain. The patient had undergone a pain management program and his functional status was getting better. prescribed Lyrica and hydrocodone and recommended continuing exercise program.

On December 29, 2011, noted that the patient had participated in the pain management program for 20 days making good progress. The progress indicated continuing treatment for at least five more days. Therefore, recommended continuing the CPMP.

On December 30, 2012, requested approval of five sessions of pain management program for two weeks, a total of 40 hours.

2012: Per the utilization review dated January 4, 2012, the request for 10 sessions of pain management program was denied based on the following rationale: The patient complained of chronic pain which resulted to limited functioning, reduced employment, anxiety, and depression and sleep problems. As per latest medical report dated December 29, 2011, the patient's physical performance was almost within normal limits with a current pain rating scale of 2-4/10 from 8/10. Psychological status had also markedly been stabilized and improved and integrative summary reports showing a well-documented progress of the patient was noted from submitted records. However, there was no indication in the report that the goals of treatment could not be addressed through other more specific but less intensive interventions than a CPMP. Additionally, the requested service was in excess of the recommended number of sessions and there was no documentation of a clear rationale for the specified extension and individualized care plans explaining why improvements could not be achieved without an extension. Furthermore, suggestions for treatment post-program as well as post-treatment medication management had not been submitted. Therefore, the medication necessity of the request was not substantiated. nurse, confirmed the patient's gains from treatment provided to date and that she would not be able to provide documentation why the current goals of treatment could not be addressed through other more specific but less intensive interventions than a CPMP. Therefore, the medical necessity of the request had not been substantiated.

On January 10, 2011, recommended reconsideration for the request for pain management program five sessions a week for two weeks.

Per the utilization review dated January 19, 2012, reconsideration of the request for 10 sessions of CPMP was denied based on the following rationale: The clinical documentation provided indicated the patient had complaints of pain to the lumbar spine. The patient had participated in 20 sessions of a CPMP to date. Guidelines recommend chronic pain programs and indicate total treatment duration should generally not exceed 20 full-day (160 hours) sessions. Guidelines indicate treatment not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The clinical documentation provided indicated the patient had participated in 20 sessions of CPMP to date. The patient was noted to have improvement in lumbar range of motion (ROM), lifting and pain. The patient was noted to have stabilized anxiety and depression. Guidelines recommend treatment duration in excess of 160 hours requires a clear rationale

for the specified extension of reasonable goals to be achieved; however, there was lack of documentation provided indicating a clear rationale for the specified extension and reasonable goals to be achieved with the continuation in a CPMP. As such, the request for additional pain management program for five times a week, for two weeks for 40 hours, lumbar spine, was non-certified.

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

In summary, it is my opinion after reviewing the medical records that I support the decision that has been made to deny any additional pain management program five days a week times two weeks, 40 hours, based on the ODG Guidelines. The patient has already had conservative management prior to two surgeries with postoperative care and rehabilitation documented. He has had extensive treatment, in my opinion, already and is still symptomatic. His treating doctor states that he has post laminectomy syndrome and he is being followed for pain control. has already documented that he would like to try to wean the patient off of his medications. Also, x-rays as well as MRIs, had supported that he had a degenerative condition with documenting degenerative joint disease, which is not expected to improve with time. However, this is not work-related and this is based on causation of age. There is documentation also regarding his participation in a work-hardening program and then later in a pain management program, in which he had made good progress. It appears that the claimant's condition has plateaued.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**