

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** January 10, 2012

**IRO CASE #:**

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

10 additional sessions of Chronic Pain Management Program 97799

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

The reviewer is a clinical psychologist/neuropsychologist licensed in the practice of psychology in Texas. He is listed in the National Register of Health Service Providers in Psychology. He is a member of the American Psychological Association and the International Neuropsychological Society. He is experienced in the evaluation and treatment of individual's with chronic pain, depression, and anxiety.

**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 (12/19/11, 12/23/11)

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- Office visit (12/08/11)

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- Office visit (12/08/11)
- Utilization reviews (12/19/11, 12/23/11)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who injured herself on xx/xx/xx. There is a history of cervical, thoracic, and lumbar pain complaints; however, the mechanism of injury is unknown.

On December 8, 2011, LPC, performed a chronic pain management evaluation. She noted that the patient had been attending the cognitive pain management sessions and had completed eight of the 10 authorized sessions. The patient continued to progress toward her goals and showed the ability to improve in daily activities of her life. She participated in the assignments, assigned homework and frequently shared her thoughts with the group members. She was learning adequate coping mechanisms to deal with the multifaceted deficits that were occurring as a response to her injury. The patient demonstrated the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce. Currently, she scored 28 on the Beck Depression Inventory versus 39 previously, 22 on the Beck Anxiety Inventory versus 25 previously, 1 on the Screener and Opioid Assessment of Patients in Pain-Revised, which was 9 on the previous assessment. Ms. requested 10 additional sessions of the chronic pain management program (CPMP) in order to return to a higher level of function and return to the workforce.

Per utilization review dated December 19, 2011, the request for 10 sessions of CPMP was denied with the following rationale: *"The clinical indication and necessity of this procedure could not be established. The patient's baclofen had been discontinued. However, there is no report/documentation of objective, clinically meaningful improvement in physical output parameters, functional status and ADL, pain behavior, social functioning external to the program, and/or vocational preparation. The submitted table of "treatment plan" did not record the patient's actual performance; it merely includes arbitrary round numbers as goals, not observed clinical output. The measurement of short-term progress utilizing "pain levels" was not clinically meaningful. The validity of linear "pain scales" for such assessment in persons with chronic benign pain syndromes had not been established and objective measurement in this fashion was not possible [ACOEM, (2008), Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed; p. 102]. The measurement of short-term patient progress with self-report psychometric instruments was not meaningful (the validity of utilizing such instruments in this repeated fashion within a chronic pain management program had not been established) and did not demonstrate clinical progress. There was no plan or protocol for discontinuing the tramadol, Dr. offered that it did not need to be weaned and that the patient "would be off it by the end of the program." This was not a plan. The report documented that the patient had moved from "taking medications as proscribed" to "an as needed basis." There was no medical documentation to support this change; and p.r.n, use of opiates generally results in higher levels of pain complaint and drug usage than time-contingent dosing...That pattern provided a potential reinforcer for the patient's pain and illness behavior, which the program was putatively designed to extinguish. There was insufficient evidence that appropriate progress in relevant parameters in the program had been obtained and any change in treatment plans to address this. There was insufficient evidence that appropriate progress in relevant parameters in the program had been obtained and any change in treatment plans to address this. I am not able to establish a basis that continuing this treatment was both reasonable and necessary at this time. Non-approval is recommended."*

Per reconsideration review dated December 23, 2011, the request for the additional 10 sessions of CPMP was denied with the following rationale: *“The claimant had already completed 10 visits in the chronic pain program. A recent PPE or FCE has not been performed or provided to support objective functional improvement from the 10 visits in the program already provided. There was no evidence the claimant was functionally limited by the chronic pain, in order to support the need for the requested program. There is no evidence of lower levels of care with psych prior to the current request for this tertiary care-program. Documentation that the claimant is willing to change has not been provided. There is no evidence the claimant has failed all other treatment methods. There is no evidence the claimant has been treated with an anti-depressant or has other lower levels of care for psych prior to the current request. The claimant has never been on an anti-depressant since the date of injury despite the depression scores. There is no evidence of attempts to return this claimant to modified work duties or full duty work status prior to the current request. A return to work duties has the best long-term outcome per ODG, even if the claimant requires a gradual transition to full duty work status. There is no written job verification from the employer for this claimant to return to, nor is there a job description/job demand per the employer to support the current request. The claimant did not meet the ODG criteria for the current request. The current request is not consistent with the evidence-based guidelines, ODG. Based on the documentation provided, objective, and subjective findings this request is not medically reasonable and necessary. Non-Authorization is advised.”*

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

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.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment must be made available upon request at least on a b-weekly basis during the course of the treatment program.”

The documentation provided for review does not include any objective or subjective measures of the claimant’s physical performance or functional abilities. There is a treatment plan which lists specific goals for time and repetitions of physical activities but the claimant’s actual performance is not listed any where in the records. Although this formed part of the reason for the initial denial no additional information addressing this issue was included with the request for reconsideration. Nor was there a specific plan for the weaning of medications, nor any vocational planning. Without this information the effectiveness of the treatment could not be established and thus the medical necessity of continuation of the program could not be supported.

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

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