

Notice of Independent Review Decision

DATE OF REVIEW: May 15, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799 – Chronic Pain Management Program 5 per week for two weeks total 10 sessions.

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.

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (03/19/12, 03/29/12)
- Reviews (12/19/11, 12/21/11)
- FCE (01/24/12)
- Office visits (02/15/12 – 03/22/12)
- Utilization reviews (03/19/12, 03/29/12)
- FCE (01/24/12)
- Office visits (02/15/12 – 05/01/12)

City

- Office visits (02/14/11 – 04/13/12)
- Therapy notes (04/07/11 – 04/13/12)
- Reviews (04/13/11 - 04/24/12)
- FCE (04/14/11 - 01/24/12)
- Diagnostic (05/20/11)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was pushing a wheelbarrow filled with manure from one location to another when the front of the wheelbarrow struck a pile of dirt and stopped him instantly. He was jolted forward and since he was drastically stopped, the wheelbarrow immediately started tripping over on its side. After several attempts, he prevented it from falling over on its side and experienced immediate low back pain.

On March 24, 2011, the patient was evaluated by M.D., for complaints of moderate, dull and aching low back pain located in the mid and lower lumbar spine and the left ribs. Examination showed decreased range of motion (ROM) and minimal pain in the back and mild muscle spasm over L5. Dr. assessed flank pain, low back pain and rib pain and prescribed naproxen, Flexeril and clonazepam.

In April, the patient was evaluated by D.C., for complaints of low back pain. Dr. assessed thoracic sprain/strain, lumbar sprain/strain, lumbar radiculitis and muscle spasm. From April through December, the patient underwent several sessions of physical therapy (PT) consisting of ice, electrical muscle stimulation (EMS), massage, mechanical traction and therapeutic procedures. The patient was provided Biofreeze and lumbar brace.

D.C., performed a peer review and rendered the following opinions: (1) The compensable injury was lumbar spine. (2) There was no indication of pre-existing conditions/injuries. (3) Future treatment consisting of radiographic study of the lumbar spine and PT consisting of six to eight visits was reasonable. (4) MRI was not indicated as the neurological examinations were normal. If the patient's symptomatology increased in the future, then an MRI would be indicated of the lumbar spine.

On April 28, 2011, M.D., evaluated the patient for low back pain radiating into his left anterior thigh and burning and tingling in his left anterior thigh. Examination showed bilateral lumbosacral tenderness, moderate on the left and mild on the right, minimally restricted ROM, hypoactive deep tendon reflexes (DTRs) bilaterally at the patellar levels, positive straight leg raise (SLR) on the left and decreased sensation over the left L3-L4 and L4-L5 dermatomes. Dr. assessed lumbosacral strain and prescribed Elavil, Zanaflex and a topical analgesic gel compound. Random urine drug screen was obtained which was unremarkable. Dr. opined that the patient was at minimum risk for developing aberrant behavior secondary to opioid use. He obtained MRI of the lumbar spine that revealed left-sided L5-S1 disc protrusion and central and left-sided L4-L5 disc protrusion.

In June, Dr. noted that the patient complained of ongoing low back pain with radiation into his left anterior thigh. It was noted that the patient had adverse reaction to Elavil. The patient requested for a lumbosacral support. Dr. prescribed tramadol, refilled Zanaflex and recommended discontinuing Elavil. He ordered an EMG/NCV of the lower extremities followed by an orthopedic evaluation.

In a physical performance evaluation (PPE) the patient was able to perform under light physical demand level (PDL) versus medium-to-heavy PDL required by his job. The evaluator recommended progressive strengthening program for the lumbar spine and lower extremities.

M.A., evaluated the patient and noted that the patient scored 7 on the Beck Depression Inventory (BDI) which was within the normal range of the assessment and 12 on the Beck Anxiety Inventory (BAI) which was within the low range of assessment. Ms. diagnosed adjustment disorder with mixed anxiety and depressed mood and pain disorder with both psychological factors and a general medical condition. She recommended six sessions of individual psychotherapy to address the high levels of stress and depression symptoms to help patient increase management of his chronic pain.

In July, Dr. noted that the patient had a reduction in his pain levels with medications and refilled tramadol, Zanaflex and clonazepam. Dr. recommended neurosurgical consultation and an EMG.

In an addendum peer review, Dr. opined that a second opinion neurological consultation would be indicated for accuracy of the MRI findings of the lumbar spine. Additional three to four physical therapy treatments would be indicated in the form of spinal manipulation, heat and EMS in order to stabilize the lumbar spine. He also opined that the patient could return to the work on the same job modification and there was no indication for a transcutaneous electrical nerve stimulation (TENS) unit.

On July 11, 2011, M.D., performed a peer review and rendered the following opinions. (1) The medical record indicated that the patient injured his lower back when pushing a wheel barrel. It was possible that one might sustain a lumbar sprain as described by ICD-9 code 847.2 while pushing a heavy wheel barrel. (2) The apparent diagnosis of a lumbar sprain was a direct result of the work-related injury of xx/xx/xx. (3) Medical records did not clearly document a pre-existing condition or injury that might have been aggravated or exacerbated by the work-related event of xx/xx/xx. (4) It appeared that the treatment till date had been reasonable, necessary and met accepted standards of care including office visits, diagnostic evaluation, referrals or physical therapy (PT). (5) Evaluation by a chiropractor for ongoing treatment for a maximum of 10 visits was reasonable. Follow-up with prescribing physician every three months would be reasonable if the patient was continued on prescription medications. (6) There was no indication for additional supervised medical treatment including additional office visits, further diagnostic testing, any type of surgery, durable medical equipments (DME) or PT. (7) If the patient was to take an appropriate oral pain medication then the continued provision of such a medication would be reasonable and appropriate. (8) The MRI of May 20, 2011, showed only nonspecific degenerative changes and there was no evidence of a specific traumatic injury

that could be attributed to the work-related event of xx/xx/xx, or evidence of specific nerve root compromise.

On July 14, 2011, M.D., a neurosurgeon, evaluated the patient for low back pain. Examination showed limited back motion and tenderness in the lumbosacral spine, positive SLR on the right and reduced Achilles jerk on the right in comparison to the left. The neurological examination was unremarkable. Dr. assessed left-sided L5-S1 disc protrusion and central and left-sided L4-L5 disc protrusion. He recommended conservative treatment and referred back the patient to Dr. for continuation of therapy. The patient was to continue tramadol.

In September, Dr. noted that the patient complained of persistent burning and tingling in his left anterior thigh as well as left-sided low back pain with radiation of pain into his left anterior thigh. The patient was utilizing tramadol, Zanaflex and clonazepam. Dr. recommended discontinuing tramadol, prescribed Lortab and refilled Zanaflex.

From September through November, the patient was under the care of Dr. . He complained of back and leg pain. Dr. recommended PT, work hardening and continuing medication. He opined that the patient was totally disabled for any type of gainful employment.

In a functional capacity evaluation (FCE), the patient continued to perform under light duty capacity. Dr. recommended work conditioning program (WCP).

On November 1, 2011, M.D., performed a designated doctor evaluation (DDE) and opined that the patient had not reached maximum medical improvement (MMI). He opined that the patient could benefit from PT and epidural steroid injections (ESIs). He could return to work with restrictions.

From December 12, 2011, through January 19, 2012, the patient attended work conditioning program (WCP) at Alivio Health Center.

In an addendum peer review dated December 19, 2011, Dr. opined that the patient had undergone all reasonable and appropriate treatment for his work-related lower back injury. There was no indication for additional visits, further diagnostic testing, surgery, DME, PT or medications such as clonazepam, Zanaflex and tramadol.

On December 20, 2011, M.D., performed a DDE and assessed clinical MMI as of November 1, 2011, with 5% whole person impairment rating (WPI) rating.

In an addendum dated December 21, 2011, Dr. opined that there was no indication for further treatment or for WCP as the patient was at MMI.

In December, the patient was seen by Dr. for difficulty in bending, stooping, squatting, sitting, standing, recurrent back movements, climbing stairs, getting in an out of the car, up and down from the chair. He noted that the patient was under the care of Dr. for work hardening. Examination showed positive leg raise on the right and radicular pain in the right lower extremity. The patient had great difficulty on walking on heels and toes; pinprick was reduced in the dermatomes supplied by L5 and possibly S1. The patient also had intermittent pain and

numbness to the right lower extremity and some coccyx pain. Dr. prescribed Vicodin, hydrocodone and Tylenol and referred the patient back to Dr. for continuation of work hardening. The patient was recommended to take his pain medication and use donut while sitting. Dr. also recommended lumbar laminectomy and discectomy.

2012: On January 16, 2012, the patient underwent functional ability evaluation which placed him at the indeterminate PDL. However, based on the testing he would be considered at least capable of medium PDL.

From January through March, the patient was under the care of Dr. and was treated with therapy. Dr. prescribed an exercise band, Biofreeze, ice pack and lumbar support brace

In an FCE the patient again qualified under light duty capacity and was recommended chronic pain management program (CPMP).

On February 15, 2012, , M.A., evaluated the patient and noted that he scored 11 on the BDI which was within the normal range of assessment and 17 on the BAI which was within the moderate range of assessment. She diagnosed adjustment disorder with mixed anxiety and depressed mood, pain disorder with both physiological factors and a general medical condition. Ms. recommended CPMP with both behavioral and physical modalities as well as medication monitoring.

On March 14, 2012, Dr. requested for CPMP.

Per utilization review dated March 19, 2012, the request for CPMP was denied with the following rationale: *“Deny. At the present time for the described medical situation, Official Disability Guidelines would not support this specific request to be one of medical necessity. For the described medical situation, the above noted reference would not support this specific request to be one of medical necessity, as it would not appear that all lesser levels of care have been exhausted. Consequently, presently per criteria set forth by the above noted reference, medical necessity for this specific request is not established.”*

On March 22, 2011, D.C., submitted the appeal for CPMP.

Per reconsideration review dated Mar 29, 2012, the request for 10 sessions of CPMP was denied with the following rationale: *“This request is for 10 sessions of CPMP. Reports level pain at 4 with range of 2-7. BDI = 11, BAI = 17, neither of which is significant. SOAPP = 12, low range. FABQ PA = 12, work = 23 no significant fear/avoidance. Again the psych evaluation catalogs many emotional issues, but these are not substantiated by psychometric testing. Further, there is no testing, such as MMPI-2 that assesses the validity of symptoms complaints. Takes Hydrocodone and clonazepam, unknown dosages. Has lumbar disc protrusion and some positive findings on EMG so he may be a surgical candidate although this is unknown. Job PDC level is Medium-Heavy. He functions at light PDC level at present. On FCE sub-maximal effort noted on rapid exchange grip. Negative Waddell’s signs. Called requestor, Dr. at: 8:40 AM on March 29, 2012. LM for call back by 2:00 PM on 3/29. I asked why a work hardening was not requested, given the low psych scores. He said he was not sure why this had not been requested, but he understood. I also pointed out that there are some*

positive physical findings and it is not clear if he is a surgical candidate. He said he would look into that. The request for CPMP does not meet ODG guidelines for 2 reasons. First, there is no evidence of major involvement of psychosocial issues in this case, so that the intensive level of care involved in a CPMP is not demonstrated to be necessary. Second, it is unclear if the patient is a candidate for surgery.”

On April 13, 2012, Dr. placed the patient on full duty. The report is illegible.

On April 24, 2012, Dr. performed a DDE and assessed clinical MMI as of January 13, 2012, with 5% WPI rating. It was noted that the patient started active PT on December 10, 2011, and finished 14 sessions on January 13, 2012, with documented clinical improvement in pain control and ROM in accordance with recommended ODG guidelines treatment. He was able to return to work from November 13, 2011, to the present.

On May 1, 2012, a request for medical dispute resolution was made.

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

Mr., according to the records, is on minimal pain medications, has been released to work full duty, was found to be at clinical MMI and received a 5% WPI. In addition, his BDI and BAI are not significant and CPMP is not justified under 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