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Notice of Independent Review Decision

November 6, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours/10 sessions of CPMP

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

Board Certified Physical Medicine and Rehabilitation Physician

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.

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 (09/07/12, 10/15/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

LHL602.

The patient is a male who was injured. A heavy commercial overhead door, fell down and hit him on top of his head on the left side.

M.D., performed a designated doctor evaluation (DDE). The DDE report contains the following information: *“Following the injury, the patient had laceration to the scalp that measured 3 cm in length and that was sutured. Dr. ordered a computerized tomography (CT) scan of the head due to persistent discomfort. He also noted ongoing headaches and dizziness. On December 7, 2010, Dr. ordered magnetic resonance imaging (MRI) of the head because of vertigo. It was noted that the patient continued to have a diagnosis of head contusion, headaches and vertigo. On April 1, 2011, Dr. referred the patient to a neurologist. Dr. evaluated the patient for headaches and posterior cervical pain. He diagnosed closed head injury and recommended tramadol for pain control and nortriptyline for headaches. On May 18, 2011, the patient was noted to have completed testing. It was felt that the patient had diagnoses of adjustment disorder with mixed anxiety and depressed mood as well as pain disorder with both psychological factors and general medical condition. He had chronic pain, financial struggles, multiple social losses and problems with family. The patient then completed a neuropsychological evaluation. Conclusion after extensive neuropsychological testing was that the patient was not at neuropsychological maximum medical improvement (MMI) from October 27, 2010. Dr. noted that the patient needed additional medical testing, audiometry, visual and neurological evaluation. Dr. felt that the diagnoses were postconcussion syndrome, refractory pain, depression and anxiety. He did believe that eventually the patient could resume working from a neuropsychological standpoint and that some accommodations and restrictions would probably be required. He noted presently the patient was not capable to return to work and the issue should be revisited after additional treatment was provided and before October 27, 2012. The patient started chronic pain management program (CPMP) on May 12, 2011. After review of Dr. report, it was noted that there was a statement in the report that definitely was concerning. He stated that Dr. report was invalidated because Dr. did not receive the raw data. Dr. noted that the patient’s pain diagram looked exactly the same as it did on the first evaluation. His pain level was 6/10. It was described in the left side of the head as well as into the left paracervical region and left proximal trapezius region. The patient noted that his headaches were persistent on a daily basis in the frontal temporal region. He stated that he felt like he has a hangover. He had been followed by a neurologist who had diagnosed chronic headaches. He had MRI and CT scans, both of which were negative. He had no cervical MRI to address the cervicgia that he had. He was utilizing Tylenol for pain. He had no medications since his pain management program was stopped.”* Dr. diagnosed cervicgia, rule out cervical spine abnormalities, posttraumatic headaches, mild traumatic brain injury and post-concussive syndrome. He opined that the patient was not at MMI on the date certified by Dr. because the patient had further treatment. The patient had at least ten sessions of pain management for which there were no notes available. The patient stated that he did complete the program for the timeframe allowed, but was not certified when further treatment was requested by the providers. For the issue of the skin/scalp, the patient had a 3-cm laceration which was tender to palpation. Since this was only the accepted

diagnosis, Dr. assigned 1% whole person impairment (WPI) rating. He recommended MRI of the cervical spine to make sure that there were no abnormalities.

On January 11, 2012, MRI of the cervical spine showed disc herniations at C4-C5 and C5-C6, spinal cord abutment at C4-C5 and C5-C6 without spinal cord signal change and C5-C6 mild left neural foraminal narrowing.

On January 19, 2012, Dr. reviewed the MRI findings and opined that the C4-C5 and C5-C6 disc herniations were a part of the injury. This was also accompanied by the resultant spinal cord abutment and the mild left neural foraminal narrowing. The extent of compensable injury also included mild traumatic brain injury and posttraumatic headaches and post-concussion syndrome. The patient was in a TBI or CPMP and was making good progress according to him. The patient was not at MMI and therefore no IR should be applied. Dr. had made a big point of trying to diagnose alcoholism in the patient which was very difficult to do in one visit. The patient needed to complete his TBI and CPMP. He also needed to be treated for his cervical spine problems at which time he would be able to be rated at MMI.

On August 15, 2012, the patient underwent a functional capacity evaluation (FCE). Based on the results of the FCE, the patient did not demonstrate the necessary lifting, carrying, pushing, pulling or reaching tolerance to return to his previous position as a warehouse worker for Labor Service Company at DHL. The evaluator recommended that the patient should initiate a CPMP. The FCE contained the following additional records: *“Following the injury, the patient stated that he was dazed and confused by the impact and did not know what had struck him and did not lose consciousness. He noticed dripping of blood from the laceration he had suffered on his head from the impact. He stated that co-worker immediately rendered him aid. EMS was contacted. The patient was transported by EMS to Hospital where he was examined, prescribed medication, stabilized and instructed to seek medical attention. He had three staples put on his head for laceration. He followed with doctor at Hospital to remove the staples and because he was complaining of persistent headaches and cervical region pain, he underwent a CT scan of the head.”*

On August 22, 2012, XXXX evaluated the patient for ongoing complaints of pain in the neck. The patient reported that his pain seemed to radiate up through his head with more severe pain on the left side. He described his pain as intermittent, throbbing, shooting, tingling and aching. Objective findings included decreased appetite, sadness or down feelings, insomnia, decreased energy, irritability, inability to get pleasure out of life, increased sensitivity, crying episodes, decreased motivation, decreased libido, discouragement about the future, muscle tension, difficulties adjusting to the injury, fear of re-injury, concentration difficulties, increased concern about physical health and increased pain with emotion upset. The patient scored 19 on Beck Depression Inventory II (BDI-II) which was within the mild range of the assessment. At the time of reassessment, the patient scored 21 within the moderate range of assessment. The patient scored 13 on Beck Anxiety Inventory (BAI) which was within the mild range of the assessment. At the time of reassessment, the patient scored 21 within the moderate range of the assessment. Ms. XXXX assessed adjustment disorder with mixed anxiety and depressed mood and pain disorder with both psychological factors and a general medical condition. She recommended ten sessions of a behavioral multidisciplinary CPMP.

Per the utilization review dated September 7, 2012, the request for ten sessions/80 hours of chronic pain management was denied based on the following rationale: *“Based on the medical records submitted for the review on the above-referenced claimant, 80 hours of chronic pain management requested is not approved. Claimant does not meet ODG criteria below. He is currently on no medications. His FCE indicates he can do medium-to-heavy work. He was released to return to work sometimes in April 2012 and chronic pain management request was cancelled because he had returned to work. There is no indication for chronic pain management because he had returned to work. There is no indication for chronic pain management at this time since claimant apparently did well and was released to return to work.”*

Per the reconsideration review dated October 15, 2012, the appeal for ten sessions/80 hours of CPMP was denied based on the following rationale: *“This is an appeal of denial for CPMP. The original denial was based on the fact that when the reviewer spoke with requestor, it was determined that the patient had returned to work, and therefore, the CPMP was no longer needed. Now the denial is being requested again, and in the appeal Dr. does not respond to the issue of return to work, but simply states the patient meets the criteria for CPMP. Patient was hit in the head by a 30-lb. plate. Has cervical disc herniations but does not appear to be a candidate for surgery. Went through a cognitive retraining program. The psychological evaluation reassessment report for CPMP dated August 21, 2012, catalogs multiple psychological complaints including depression, anxiety and sleep disturbance. BDI and BAI are both 21, in the low moderate range. No validity measures. Uncertain what medication he is taking now. Pain is level 6. Sleeps four hours per night. The psychological evaluation does not address whether the patient has been through a brain injury program,*

nor address the neurological evaluation. FCE reveals decreased cervical ROM and flexibility, decreased grip strength, decreased PDL level. However, I cannot determine PDL level at present from the FCE; although denial determination states he was released to return to work and can function at medium to heavy PDL level. Request for 80 hours of CPMP. Called requestor at 10:40 a.m. on October 9, 2012. Left message for call back by 2:00 p.m. in October 12, 2012. Spoke with requestor at 1:30 p.m. on October 12, 2012. Dr. told me that the patient had been released to return to work, but was unable to maintain working for more than a few months. The patient had six sessions of cognitive rehab authorized but did not complete these because he was released to return to work. He did not have results of neuropsychological evaluation. He stated that the patient is taking only tramadol. I asked him to interpret the FCE and Dr. stated the patient is functioning at a heavy PDL level now. I asked why the patient would need a CPMP if he is at heavy PDL, already takes tramadol and was released to return to work a year ago. He responded that is a good question. The patient clearly does not meet the criteria for CPMP, in that he has accomplished all functional goals and is taking no pain medication.”

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

Based upon the recent functional analysis of claimants work capabilities, his treating M.D. placed the claimant at a heavy PDL per phone conversation on 10-12-12. There is no reported use of psychological/psychiatric medications in relation to the behavioral diagnoses. There are no current objective exam findings supportive of measured functional deficits to support claimant’s inability to return to work since treating M.D. opined claimant at a heavy PDL functional capacity.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES