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Notice of Independent Review Decision

Date: December 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program/80 hours

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

Chiropractor

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:

ODG criteria and ACOEM (2008) guidelines has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx, was loading boxes on shelves when another employee inadvertently hit her in the back with a pallet-jack. She fell, hitting her head and her back on the concrete floor. She had loss of consciousness for a few seconds. She experienced an immediate onset of sharp pain in her neck, middle and lower back and her head after the fall.

On April 30, 2012, evaluated the patient for an initial clinical interview in order to assess the patient's ongoing psychological state, specifically related to her treatment progress. The treating physician had expressed concern that the patient might not be receiving maximum benefit from her medical treatment as a result of possible behavioral health factors resulting from her injury that might be

acting as barriers to her full recovery. The Beck Depression Inventory-II (BDI-II) score was 36 which categorized the patient in the severe range of depression. The Beck Anxiety Inventory (BAI) score was 29 which categorized her in the severe range for anxiety. The Fear Avoidance Beliefs Questionnaire (FABQ) indicated a severe degree of fear avoidance. Diagnosis was adjustment disorder with mixed anxiety and chronic depressed mood. recommended six sessions of individual psychotherapy over eight weeks.

Following treatment history is noted report: *On xxxxx, the patient was evaluated at xxxxxx. Diagnosis was cervical strain and morbid obesity. She was prescribed acetaminophen, bio-freeze and was recommended modified activity.*

On August 4, 2011, the patient was evaluated. Neurological exam was normal and x-rays of the cervical spine showed no fracture. Assessment was face and scalp contusion; brief loss of consciousness of 30 minutes or less and contusion of buttocks.

On August 23, 2011, computerized tomography (CT) scan of the abdomen and the pelvis with contrast was unremarkable.

On September 30, 2011, MRI of the cervical spine showed no significant disc osteophyte complexes, spinal canal stenosis, or neural foraminal narrowing. MRI of the lumbar spine showed a 2-mm mild disc bulge at L3-L4 with mild-to-moderate congenital spinal canal stenosis; a 2-mm mild diffuse disc bulge at L4-L5 with mild bilateral facet joint hypertrophy and moderate congenital spinal canal narrowing and mild-to-moderate left neural foraminal narrowing; straightening of the normal cervical lordosis which might be related to muscle spasm and probable left C4 facet subchondral cyst.

On November 7, 2011, assessed cervical disc displacement, cervical radiculitis, cervicgia, cervical myofascial injury and recommended evaluation for epidural steroid therapy; chronic pain management therapy program if symptom logy did not abate.

On November 18, 2011, in an initial functional capacity evaluation (FCE), opined that the patient was functioning in the sedentary physical demand level (PDL), as she was able to dynamically lift 0-13 lbs. A recommendation was made for two weeks of eight hours daily chronic pain management program (CPMP).

On November 18, 2011, in a clinical psychological interview, diagnosed cervical sprain/strain, pain disorder associated with work-related injury, depressive disorder, NOS, with major depressive features associated with work-related injury; anxiety disorder, NOS, related to injury medical, condition.

On January 25, 2012, performed a behavioral health re-evaluation and recommended that the patient would benefit from individualized psychotherapeutic intervention to improve emotional adjustment and coping skills

and in turn, will improve her motivation and help her perceive her situation more realistically; and will improve her ability to rehabilitate.

On April 20, 2012, the patient underwent physical therapy (PT) evaluation. She had signs and symptoms suggestive of chronic cervical pain and dysfunction. It was opined that the patient would benefit from active physical rehabilitation service.

On April 24, 2012, in an initial clinical interview, the patient reported severe depression, severe anxiety and high levels of stress. She felt isolated and had difficulty in communicating due to her fear to be a burden. She exhibited poor pain management skills, possible neurological symptoms and reported experiencing severe headaches, state of confusion and disorientation. She had sleep disturbances. The patient was given a referral for psychotropic medication and recommendation for neurological examination (was discussed). Six sessions of individual psychotherapy were recommended.

Per utilization review dated May 3, 2012, the individual psychotherapy sessions were approved.

On October 18, 2012, the patient underwent physical performance evaluation (PPE) and demonstrated the ability to perform at light duty PDL. She failed to meet her medium PDL required by her job. The evaluator opined that the patient would benefit from a specifically designed pain management program to quickly improve her return to work status.

On November 6, 2012, the patient underwent behavioral health assessment for participation in a multidisciplinary chronic pain program. It was noted that *the patient was seen, for a neurologic consultation with the chief complaints of headaches, insomnia, depressed mood and affect. The impression was status post closed head injury with mild brain concussion and posttraumatic reactive insomnia and reactive depressed mood disorder. recommended electroencephalography (EEG) (request denied) and follow-up.* It was also noted that the patient had completed six sessions of individual therapy between May 15, 2012, and June 26, 2012. The BDI-II score was 24 which placed the patient in the range of moderate depression level. The BAI score was 15 which placed the patient in the mild range of anxiety. assessed adjustment disorder with mixed anxiety and chronic depressed mood and recommended 80 hours of chronic pain management therapy.

On November 8, 2012, noted that the patient was overall doing worse since her last visit. She had pain in the lower back and pain level was 6-7/10. The medial branch block was denied by the xxxxx. She was utilizing Ultram, Cymbalta, ibuprofen and Prodin which were helping her increase function and activities of daily living (ADL). assessed fair pain control with ongoing regiment and worsening condition. He opined that a CPMP that was comprehensive in nature would be beneficial for the patient. Modalities such as rehabilitation, PT, psychological counseling and biofeedback could help her deal with pain and

improve coping strategies. This would ultimately maximize her chance for improved function. She had exhausted all conservative care and surgery was not indicated at that time. The patient was to advance to home exercise program (HEP). The patient was prescribed Terocin.

On November 14, 2012, opined that the patient would be a good candidate for CPMP in order to restore complete function and provide her with the best opportunity to return to the workplace. He recommended 10 sessions of CPMP eight hours a day, followed by a functional capacity evaluation (FCE) to make sure he continued to approach her job demand level. This program would help rehabilitate her physical and emotionally to return her to the work environment.

Per utilization review dated November 20, 2012, the request for CPMP for 80 hours was denied with the following rationale: *"I discussed this case and requested procedure with. The clinical indication and necessity of this procedure could not be established. The mental health evaluation of November 6 finds impression of adjustment disorder. This is inconsistent with a "chronic pain syndrome" necessary for treatment in this type of program. A psychological evaluation completed on November 8, 2011, apparently found a pain disorder, depressive disorder, and anxiety disorder. The provider said she "apologizes" for this, and the diagnosis should be pain disorder at this time. This is clearly a problem of inattention to the current clinical presentation in this case. In addition, the current evaluation is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employee psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms, and to help design and predict response to treatment; and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e., pain complaint, behavior, and disability), to enable a "better understanding of the patient in their [sic] social environment," or to provide "a cogent explanation for the identified complaints and dysfunction." A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, based on the above assessment. There is baseline and goal data expressed as current and projected psychometric scores. This is inappropriate. The measurement of short-term patient progress with self-report psychometric instruments is not meaningful (the validity of utilizing such instruments in this repeated fashion within a CPMP has not been established) and would not demonstrate clinical progress. The proposed measurement of short-term progress utilizing "pain levels" is also not clinically meaningful. The validity of linear "pain scales" in persons with chronic benign pain syndromes has not been established, and objective measurement in this fashion is not possible. Such an approach "...is not clinically helpful for most patients with chronic pain," [ACOEM, (2008), Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed., p. 102). Such an approach has a clear tendency to reinforce pain behavior, the extinction of which is generally considered as a paramount goal in such a program, though it is not mentioned in this request or*

the evaluations. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended.”

On November 26, 2012, a reconsideration request for CPMP was submitted.

Per reconsideration review dated November 30, 2012, the request for 80 hours of CPMP was denied with the following rationale: *“A peer to peer was attempted but was not successful on two attempts on separate days. A recent PPE or FCE has not been performed or provided with evidence of max valid effort being performed throughout with findings present to support the current request. The last FCE provided indicated the claimant was capable of occasional dynamic lifts up to 20 lbs, which falls into the medium PDL, the same PDL required for normal work duties. There is no evidence of lower levels of care with psych prior to the current request for this tertiary care program. The negative predictors have not been addressed. 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 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 does 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.”*

Addendum: *“The claimant has completed 6 sessions of individual psych which dropped her psych issues into the mild per xxxx. The sessions were completed from May to June 2012. The claimant is currently not taking any narcotic medications. Weaning off medications does not require the current request per the evidence-based guidelines. It is not clear whether the claimant will be returning to warehouse work or not, that is yet to be determined and won't be decided until they are into the program per xxx xxx. A return to work job has not been provided or outlined which is necessary to maintain the increased function following the program or the claimant will deteriorate back to her current condition without a physically demanding job position to maintain a higher PDL. The claimant is already capable of occasional dynamic lifts up to 15 to 20 lbs, which falls into the light to medium PDL. Occasional dynamic lifts were not provided nor were static or Niosh lifts. There was no indication the claimant was performing maximum valid effort during the lifts that were tested. A return to work duties has the best long-term outcome per ODG even if the claimant requires modified work duties to transition to full duty work status. My prior decision remains unchanged. Non-certify the current request.”*

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

Based on the documentation provided, the claimant has reached a PDL to adequately perform gainful employment. No attempt has been made to return the

claimant to any type of work. As stated above “A return to work duties has the best long-term outcome per ODG even if the claimant requires modified work duties to transition to full duty work status.”

Therefore, it is my opinion that the decision of Non-certification be upheld.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**