

Maturus Software Technologies Corporation  
881 Rock Street  
New Braunfels, TX 78130  
Phone: 800-929-9078  
Fax: 800-570-9544

---

Notice of Independent Review Decision

**April 1, 2014**

**IRO CASE #:**

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

Chronic pain management program (CPMP) (97799) five per week for two weeks, total 80 units (10 sessions).

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

**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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who injured his low back, mid-back and neck on xx/xx/xx. On January 7, 2013, the patient was evaluated. The patient underwent a psychological evaluation and functional evaluation. His functional evaluation had revealed significant physical limitations. The behavioral observations revealed that the patient was suffering from anxiety, depression, muscular tension and had since developed chronic pain symptoms and was unable to return to work. The patient experienced high levels of stress daily. The patient had attended psychotherapy which was designed to assess and address pain management, coping skills, emotional distress and negative thought patterns and to help him decrease and eliminate symptoms of depression and anxiety. Unfortunately, the patient had demonstrated minimal improvement in those areas. As therapy

continued, it became apparent that although patient's coping skills were improving they were still weak due to patient being easily discouraged and too emotionally unstable to be consistent to follow through with treatment plan. The patient had shown progress in decreasing his level of pain throughout treatment. The patient reported that he was suffering from severe fear of future re-injury and other return to work concerns. He scored 36 on Beck Depression Inventory-II (BDI-II) consistent with severe depression and 28 on Beck Anxiety Inventory (BAI) consistent with moderate anxiety. The evaluator requested 10 sessions of behavioral multidisciplinary chronic pain management program (CPMP). Per evaluation summary the findings were consistent with lumbar sprain/strain, thoracic sprain/strain and cervical sprain/strain. His diagnosis and chronic pain were causally related to his work injury. The patient's critical work demands included ability to work at a heavy physical demand level (PDL).

On August 30, 2013, administered cervical epidural steroid injection (ESI) for cervical disc herniation and cervical radiculitis.

On September 10, 2013, evaluated the patient for neck injury with spasms and stiffness. diagnosed cervical spine sprain/strain, thoracic sprain/strain and lumbosacral sprain/strain. He prescribed Ultram. The report is partially legible.

In a physical performance evaluation (PPE) dated September 19, 2013; the patient was unable to safely and dependably return to usual and customary. He demonstrated ability to safely and dependably perform at a light PDL which failed to meet the minimum job requirement for the job.

On October 7, 2013, evaluated the patient for ongoing stiffness in the areas of injury and increased pain at that time. Examination revealed taut/tender fibers palpated in the cervical region, muscle weakness detected in the cervical region and moderate muscle spasm at the upper trapezius muscle. diagnosed lumbar sprain/strain, thoracic hyperflexion/hyperextension, cervical sprain/strain, lumbar radiculitis and cervical radiculitis. The patient was in a tertiary comprehensive work hardening program (WHP).

From October 7, 2013 through October 24, 2013, the patient attended 10 sessions of WHP.

On November 5, 2013, the patient was evaluated. The report is illegible.

On November 5, 2013, noted continued improvement of neck and arm pain after the last cervical ESI. His low back had remained stiff. The radicular signs and symptoms had diminished in the legs. had maintained the patient on tramadol and Ambien. The patient had difficulty sleeping and continued to have some difficulty coping with his ongoing condition. He was using cervical pillow and cervical traction which helped his condition in addition to and in conjunction to the portable transcutaneous electrical nerve stimulation (TENS) unit and WHP sessions. Examination revealed positive shoulder depression test for pain, increased tightness in the trapezius musculature bilaterally, myospasms of the

upper trapezius musculature with active trigger points palpated bilaterally. Kemp's test was positive for thoracolumbar pain. There was positive straight leg raising (SLR) bilaterally for lumbosacral pain at 65 degrees. Yeoman's test was positive bilaterally. Deep tendon reflexes (DTRs) were diminished in right brachioradialis 1/+2. There was diminished sensation in T1 and C8 on the right. Kemp's test was positive bilaterally and there was diminished sensation in the right S1. diagnosed cervical sprain/strain, cervical radiculitis, lumbar sprain/strain, lumbar facet syndrome and thoracic sprain/strain. He recommended additional 10 sessions of WHP.

On November 8, 2013, the patient was evaluated, for post designated doctor required medical evaluation (PDDRME). noted following treatment history: *The patient was seen for an initial consultation on February 16, 2012. The patient injured his mid to low back and neck. He began feeling sharp, burning pain in his mid to lower back, and now had muscle spasm going up into his neck with stiffness in his shoulders which concerned him. The patient reported a prior low back injury in xxxx, though he did not file a claim, received no treatment for that injury, and the pain resolved within, a couple of days The patient's examination showed no objective findings.*

*The patient was seen. This was a handwritten note, essentially illegible. The patient was referred for physical therapy. Medications included Naprosyn, Valium and an unknown medicine, perhaps Prilosec. The patient was re-evaluated on February 23, 2012, and daily progress notes for March 9, 12, 13, 15, and 16 were reviewed.*

*The patient underwent the first of many computerized range of motion (ROM) and muscle testing examinations on March 6, 2012, and was re-evaluated on March 19. The patient was said to have radiculitis in the neck and lower back, with sprain/strain of the entire spine.*

*The patient continued to receive treatment with daily progress notes of March 20, March 22, March 23, March 26 and March 27.*

*re-evaluated the patient on March 21, and the patient was told to wean off diazepam and discontinue, no new prescriptions were given.*

*The patient received chiropractic on March 30, 2012.*

*The patient had an MRI of the cervical spine on April 2, 2012. There was a central three-millimeter protrusion which effaced the cord without significant nerve root compression at C5-C6. At C6-C7, there was posterolateral protrusion present on the left effacing the cord with left C7 nerve root and foraminal encroachment. There were no acute findings.*

*MRI of the lumbar spine on April 2, 2012, showed broad-based 1-2 millimeter annular bulge effacing the thecal sac without stenosis or nerve root compromise*

*on L4-5. At L5-S1, there was a broad-based one to two millimeter annular bulge also effacing the thecal sac with effacement on the left S1 nerve root.*

*The patient was re-evaluated on April 9, 2012, and on April 10, 2012. The patient was released to light-duty on March 10, 2012.*

*evaluated the patient on May 17, 2012. The patient stated he felt pain throughout his upper neck, mid and low back. The degenerative changes in the cervical and lumbar spine were discussed, noting disc bulges. The patient continued to participate in physical therapy (PT) along with medication management "Nothing aggressive" was recommended.*

*The patient was seen on May 17, 2012, and the patient was held off work as of April 23, 2012.*

*The patient was seen on June 5, 2012, and on June 14, 2012.*

*The patient had his initial pain management interview on June 24, 2012. The patient reported that he was treated in the past for sleep difficulties. He denied any unrelated mental disorders. His Beck Depression Index (BDI) showed that he was in the mild-to-moderate range and moderate anxiety from the BAI. The patient was assessed with a pain disorder and no true psychological conditions by LPC.*

*Another functional capacity evaluation (FCE) was performed on June 14, 2012. This included the computerized ROM and manual muscle testing.*

*program director, requested that the patient be seen in a work-hardening program (WHP) with a preauthorization note on June 15, 2012. On June 27, 2012, there was a rebuttal to the peer review.*

*specialty unknown, saw the patient on July 2, 2012, for a designated doctor evaluation (DDE). The patient was seen. The history was reviewed, and the patient was examined. The diagnosis was thoracic and lumbar strain. The patient was assessed as being at Category I impairments for both the cervical and thoracic spine, and did not recommend any further treatments.*

*There was a rebuttal on July 13, 2012. sharply disagreed with the report for several reasons, noting that the patient had subjective pain complaints without objective findings. that should be a reason to continue treatment. disagreed with many of the statements regarding the MDA and ODG.*

*saw the patient at the request of the treating provider for an impairment evaluation on July 16, 2012. He did not place the patient at maximum medical improvement (MMI).*

*The patient underwent a request for services, as he was referred for an updated consultation by his treating physician and the report was issued on July 31, 2012.*

*The pain disorder was diagnosed. The patient was seen on August 7, 2012, and was held off work, as of August 13, 2012, when the patient was re-evaluated. saw the patient on August 30, 2012. The patient stated he was doing poorly. The patient initially stated he was improving with therapy and medications, but then worsened. He continued to have numbness and tingling heightened in his left upper extremity, and he had more pain radiating from his neck to his left arm. noted that the patient might have a positive Spurling's sign.*

*The patient was involved in individual therapy, with the third session documented September 21, 2012.*

*saw the patient on October 22, 2012, and once again performed a functional improvement measure test on October 26, 2012. Again using computerized ROM and muscle testing, continued the patient on medications on November 6, 2012, and the patient was seen in daily therapy on November 6 and November 9, 2012.*

*There was a progress summary note on November 12, 2012, , recommending that he continue in treatment with her for further sessions.*

*The patient was seen on November 13, November 16, November 19, and there was a reevaluation on November 20, at which time recommended a portable transcutaneous electrical nerve stimulation (TENS) unit.*

*On November 29, 2012, the patient was seen. Due to the diagnosis of radiculitis, he had recommended a cervical epidural injection. However, the carrier stated that that was non-compensable so recommended increasing the scope of the injury.*

*The patient was seen on December 4, 2012, and December 12, 2012. His fifth session of individual psychotherapy took place on December 12.*

*MRI of the thoracic spine demonstrated a posterior central protrusion measuring 2.5 millimeters in size causing mild, narrowing of the spinal canal at T7-T8. The remaining levels were normal.*

*On January 9, 2013, the patient was seen and had a treatment on January 11. The patient was seen for psychotherapy on January 16 and chiropractic on the same date. He had another functional improvement measure test with computerized ROM and muscle testing as documented on January 11, 2013.*

*On February 22, 2013, noted that the patient was scheduled for follow-up for cervical epidural injection, as the carrier had made the cervical spine compensable. The patient was seen on February 26 on February 27. The patient was seen on March 25, on March 25, and the patient received a cervical epidural injection at the Surgical Center on April 19, 2013. The patient was seen on April 23, 2013, noting that he was improving.*

*reevaluated the patient who was taking Naprosyn and Pepcid on April 29, 2013. The patient was stable, doing 60% better since his epidural injection. Two sessions of post injection therapy were recommended. The patient was stated to have an ongoing left C7 sensory deficit both to pinprick and temperature, but the other findings were normal. on the other hand on April 29 (the same day) documented diminished sensation in T1 and C8. While documented normal reflexes on that date, documented asymmetric reflexes with diminished brachioradialis.*

*saw the patient for designated doctor examination on May 2, 2013. The patient was not placed at MMI, having reported that the first injection made his condition better. Although there were no objective physical findings, diminished ROM was noted and the patient was not placed at MMI.*

*saw the patient on May 7, 2013, at which time the patient stated he was having a good day and the pain levels in his neck had decreased. The patient was showing a favorable response to his post injection PT with reduction of severity of the symptoms in his neck. The patient received treatment, and was seen again on May 8, 2013.*

The report is incomplete.

On December 3, 2013, the patient was evaluated. The patient was continue Ambien and was advised to follow-up for elevated blood pressure.

On December 4, 2013, noted that the patient was in the middle of the WHP and was progressively functioning. He recommended completing WHP.

Per PPE dated December 13, 2013, the patient demonstrated ability to safely and dependably perform at medium PDL.

On December 17, 2013, in an addendum to his November 8, 2013, post designated doctor report, diagnosed cervical sprain/strain, thoracic sprain/strain and lumbar sprain/strain (all these conditions have resolved) and Nonphysiologic findings. assigned MMI for cervical sprain/strain, thoracic sprain/strain and lumbar sprain/strain as of May 2, 2013, with 0% whole person impairment (WPI).

Per utilization review dated January 9, 2014, the request for 10 sessions of CPMP was denied with the following rationale *"I spoke on January 8, 2014, at 4:49PM CT. He verified that the claimant had attended work hardening and individual psychotherapy sessions. He stated that there was some progress, but he did not achieve all goals. stated that he did not have the RME report available for review. He could not address the non-physiologic findings. He stated that the claimant has not returned to work since the DOI. He otherwise provided the same information that was documented in the notes reviewed. Recommend adverse determination."*

On January 9, 2014, performed a designated doctor evaluation (DDE). He assigned 0% WPI rating for cervical, thoracic and lumbar regions.

On January 22, 2014, EMG/NCV of the bilateral upper extremity that showed no electrodiagnostic evidence of a cervical radiculopathy or upper extremity neuropathy.

On February 10, 2014, appealed for CPMP.

Per reconsideration review dated February 17, 2014, the request for CPMP was denied with the following rationale: *“The appeal request for chronic pain management 80 hours is not recommended as medically necessary. The initial request was non-certified noting that the patient has completed work hardening and individual psychotherapy. There was some progress, but he did not achieve all goals. The claimant has not returned to work since the date of injury. ODG guidelines do not recommend chronic pain programs when the diagnosis is primarily a personality disorder or psychological condition without a physical component. It is unclear what physical pathology is present that would cause the extent of complaints expressed by the claimant. Moreover, the claimant has already attended work hardening. ODG guidelines do not recommend repetition of the same or similar rehab programs. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The reconsideration request submitted for review fails to address the issues raised by the initial denial. Current evidence based, guidelines do not support re-enrollment in the same or similar program and note that chronic pain management programs should not be used as a stepping stone upon completion of less intensive programs. Peer-to-Peer contact was attempted and unsuccessful.*

There are a few undated office visit notes in the records.

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

The request does not meet ODG criteria for entry into a CPMP program.

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

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