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Notice of Independent Review Decision

**August 18, 2014**

**IRO CASE #:**

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

Chronic Pain Management Program - 80 hours/units - outpatient

**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.

**ODG criteria have been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, the right lower leg became infected after two weeks of just taking care of right foot on his own.

**2011:** On September 27, 2011, the patient attended an initial physical therapy (PT) evaluation. Examination was consistent with the medical diagnosis of status post below-the-knee amputation (BKA) on the right. The patient continued to experience throbbing pain on the lateral aspect of BKA.

The same day, the patient underwent a functional capacity evaluation (FCE). The evaluator noted that the patient went to due to infection and prescribed medications with no success of healing wound. The infection became so severe that he had to undergo the BKA on February 5, 2011. The patient was then fitted

with prosthesis in May 2011. The patient performed at the light-medium physical demand level (PDL).

On October 31, 2011, performed an impairment rating (IR) evaluation. noted that the patient was initially treated with antibiotics by his primary care physician (PCP). The wound was not healing and he eventually went to. He was treated with some additional antibiotics and debridement but the infection started to progress and he had to undergo a BKA on February 5, 2011. He was in the hospital for six weeks. He was eventually fitted with a prosthetic limb. The patient reported some pain in the distal residual limb and swelling varying with activity level. History was positive for hypertension, non-insulin dependent diabetes mellitus and hypercholesterolemia. assessed clinical maximum medical improvement (MMI) as of October 31, 2011, with 28% whole person impairment (WPI) rating.

**2012:** The electrodiagnostic studies dated January 17, 2012, showed bilateral S1 radiculopathy and an L4 and an L5 radiculopathy on the left. The possibility of spinal stenosis with multiple nerve root impingements should have been considered.

**2013:** On May 7, 2013, an orthopedic surgeon, performed revision of BKA right leg, with application of a 4 x 6 amniotic patch.

On June 4, 2013, noted the incision was clean and dry. There was mild swelling. discussed therapeutic options.

On July 2, 2013, recommended starting PT and follow-up in two months for recheck.

On September 25, 2013, performed an initial behavioral medicine assessment. He underwent a magnetic resonance imaging (MRI) which showed that he had an infection in the bone. Currently, the patient reported having phantom pain, sharp and cutting pain from his missing limb. had requested an evaluation for the patient's behavioral health treatment needs and participating in a chronic pain management program (CPMP). The patient rated his level of overall function at 3%. His mood was dysthymic while his affect was appropriate to content as he fought back tears when talking about the impact of his injury on his family. The Beck Depression Inventory-II (BDI-II) score was 9 indicating minimal depression. The Beck Anxiety Inventory (BAI) score was 20, reflecting moderate anxiety. Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W was 32) and non-significant fear avoidance on physical activity in general (FABQ-PA) was 5. The diagnoses were major depressive disorder (MDD), single episode, moderate, and pain disorder associated with both psychological factors and a medical condition, chronic. The global assessment for functioning (GAF) score was 59 currently. A formalized battery of psychological tests, including the Multiphasic Personality Inventory-2 (MMPI-2) and Battery for Health Improvement-2 (BHI-2) were requested.

On October 8, 2013, the patient reported discomfort with contact area of right prosthesis. He was doing well overall. recommended PT and weaning the patient off crutches.

On October 15, 2013, evaluated the patient for ongoing pain complaints. Functionally, the patient reported difficulty with all activities of daily living (ADLs) since his injury. He rated his level of overall functioning at 3%. The diagnoses were anxiety disorder and pain disorder associated with both psychological factors and a medical condition. concurred with recommendation that the patient needed to participate in the CPMP after exhausting conservative treatment. The patient would require an interdisciplinary chronic pain program in order to reduce his pain and fear avoidance behaviors while improving his physical capabilities and functioning.

**2014:** On February 10, 2014, the patient attended a physical performance evaluation (PPE). It was determined that he could not safely perform his job demands.

a licensed psychologist, evaluated the patient on February 10, 2014, for CPMP. On mental status examination, the patient's mood was dysphoric and affect was constricted but appropriate to content. The diagnosis was somatic symptom disorder with predominant pain, persistent and moderate. The patient was recommended an interdisciplinary chronic pain program to reduce pain and fear avoidance behaviors while improving physical capabilities and functioning.

On February 12, 2014, evaluated the patient for chronic pain. The right lower extremity showed some hyperesthesia of the lateral distal stump. No infection as seen. recommended participating in a CPMP. Mupirocin 2% ointment was prescribed.

On February 19, 2014, noted the patient was still having inflammation but the incision looked good. He prescribed naproxen and recommended following up in two months for a cortisone injection.

On February 24, 2014, a preauthorization request for CPMP – 80 hours/units – outpatient was submitted.

On April 23, 2014, evaluated the patient for continued participation in the CPMP. Results for assessment showed increased scores including fear avoidance beliefs about work from 27 to 32 and fear avoidance beliefs about physical activity from 13 to 15. Oswestry Disability Index (ODI) was 40% moderate and presently 32%, BAI was 17 and presently 15, BDI-II was 6 and presently 12. Visual analog scales showed pain level of 6 previously as well as presently, irritability level was 3 previously and 5 presently, frustration level was 2 previously and 5 presently, muscle tension was 4 previously and 6 presently, anxiety was 2 previously and 6 presently, depression was 2 previously and 6 presently, sleep problems were 3 previously and 6 presently, forgetfulness was 2 previously and 6 presently and

average hours slept were 7 previously and 6.5 presently. The patient was advised to continue CPMP.

In a PPE dated April 25, 2014, it was determined that the patient could not safely perform their job demands.

A request for 80 additional hours of a CPMP was submitted on May 1, 2014. It was noted the patient had completed 10 day trial of the CPMP.

On June 11, 2014, evaluated the patient for continued participation in the CPMP. Results for assessment showed increased scores including fear avoidance beliefs about work from 32 to 33 and fear avoidance beliefs about physical activity from 15 to 18. The score for coping strategies questionnaire were as follows: Distraction from 4.0 to 3.4 (improved), catastrophizing from 2.8 to 3.0 (increased), ignoring pain from 3.2 to 3.2, distancing from the pain from 2.8 to 3.0 (increased), coping self-statements from 4.0 to 3.8 (improved) and praying from 3.7 to 3.0 (improved). Oswestry Disability Index (ODI) was 32% and presently 34%, BAI was 15 and presently 21. BDI-II was unchanged at 6. Visual analog scales showed pain level of 6 previously as well as presently, irritability level of 5 previously and 6 presently, frustration level of 5 previously and presently, muscle tension of 6 previously and presently, anxiety 6 previously and 7 presently, depression 6 previously and 7 presently, sleep problems of 6 previously and presently, forgetfulness of 6 previously and presently and average hours slept 6.5 previously and presently. The previous examination was done on April 23, 2014. The diagnoses were MDD, single episode, mild and somatic symptom disorder with predominant pain, persistent and moderate. It was recommended that the patient be approved for continued participation in the CPMP in order to further increase his physical and functional tolerances and to facilitate a safe and successful return to work.

In a PPE dated June 13, 2014, it was determined the patient could not safely perform his job demands.

An additional request for 80 final hours of a CPMP was submitted on June 17, 2014. The report stated the patient had almost completed 80 hours of the program.

Per the utilization review dated June 20, 2014, the request for CPMP 80 hours/units right leg (97799) was denied, based on the following rationale: *"The patient is a hypertensive, diabetic, male who on xx/xx/xx. He is diagnosed with 897.0 (traumatic amputation of leg) and 781.2 (gait abnormality). A request was made for 80 hours of CPM program for the right leg. He has received treatment in the form of medications, rest, assistive device for ambulation, prosthesis, HEP, 12 PT visits, four sessions of Psychotherapy, injection, surgeries and CPM program. On January 14, 2011, minor surgery was performed to open the wound and get rid of the pus. On February 5, 2012, he underwent a right below-the-knee amputation. An EMG/NCV of the bilateral lower extremities on January 17, 2012, showed radiculopathy at left L4, left L5 and bilateral S1. On August 16, 2012, he*

*was able to perform at Light-Medium (Physical Demand Level). On May 7, 2013, he had revision of below-the-knee amputation. Baseline testing on November 14, 2013, showed 6/10 pain on VAS, moderate anxiety (BAI=17/63), and minimal depression (BDI-II=6/63). On April 23, 2014, he had 6/10 pain on VAS, mild anxiety (BAI=15/63) and mild depression (BDI-II = 12/63). On April 24, 2014, he was able to perform at Medium PDL. He was recommended with additional CPM program. On June 11, 2014, he had 6/10 pain on VAS, moderate anxiety (BAI = 21/63), and mild depression (BDI-II=12/63). On June 13, 2014, he was able to perform at medium PDL for a heavy PDL requiring job. He was noted to no longer have the supervisor position. Per June 17, 2014 report, he has almost completed the 80 hours of CPM program. He was on gabapentin 300 mg four times daily, two tablets of metformin 500 mg twice daily, Naprosyn 500 mg twice daily on an as needed basis, and Zocor 40 mg once daily. stated that the patient is status post multiple surgeries including a below knee amputation, hence, his progress is slow. His BDI scores are near normal. He has achieved some improvement in PDL from a baseline of light-medium after initial 10 sessions. His anxiety scores are moderate and not improved much. Pain level is 6/10. Given that there is no significant improvement in pain, work capacity, and psychological issues, it is unlikely that in additional 2 weeks he would be able to achieve heavy PDL. Based on the above cited points, the medical necessity of this request cannot be validated at this time.”*

On July 1, 2014, opined that the program had exerted a positive impact on the patient's symptoms; however, he had not met the targeted reduction of 75% in every active symptom. He required an additional 80 hours/units of the interdisciplinary pain rehabilitation program in order to extinguish active symptoms over a long term basis, maximize his functional tolerance and propel him towards a safe return to work.

Per the reconsideration review dated July 10, 2014, the appeal for CPMP 80 hours/units right leg (97799) was denied based on the following rationale: *“The patient is a male who sustained an injury on xx/xx/xx. He was diagnosed with traumatic amputation of the leg and gait abnormality. An appeal request for 80 hours of Chronic Pain Management Program was made. The previous request was non-certified on June 20, 2014, based on the grounds that given that there was no significant improvement in pain, work capacity, and psychological issues, it was unlikely that in an additional two weeks, the patient would be able to achieve heavy PDL. The records indicated that the patient was previously treated with medications, rest, use of assistive device for ambulation, prosthesis, Home Exercise Program, 12 visits of Physical Therapy, four sessions of psychotherapy, injection, surgeries, work/activity restrictions, and CPMP. On January 14, 2011, he underwent a minor surgery to open the wound and get rid of the pus. On February 5, 2011, a right below-the-knee amputation was performed. The EMG/NCV study of the bilateral lower extremities dated January 17, 2012 showed radiculopathy on the left L4, left L5 and bilateral S1. On May 7, 2013, the patient had revision of below-the-knee amputation on the right leg. In the Physical Performance Evaluation report dated April 25, 2014, it was mentioned that the patient has completed 80 hours of chronic pain management. In the note dated*

May 1, 2014, it was mentioned that the patient has been recently authorized for a ten day trial of an interdisciplinary CPMP which he has almost completed. An additional 80 hours was requested. From November 14, 2013, updated objective findings were as follows: increased FABQ-WA score of 32 from 27, increased FABQ-PA score of 15 from 13, decreased BAI score of 15 from 17, increased BDI score of 12 from 6, and increased PDL of Medium from Light-Medium. The note dated June 17, 2014, stated that patient was approved for 80 hours of CPMP and had almost completed the 80 hours. At this time, final 80 hours of the program were requested. Updated documentation submitted for review includes the reconsideration request dated July 1, 2014. This did not address the above-mentioned reason for non-certification. It stated that the patient had completed 80 hours of CPMP from April 23, 2014. Updated objective scores include the following: increased FABQ-WA score of 33 from 32, increased FABQ-PA score of 18 from 15, increased BAI score of 21 from 15, unchanged BDI score of 12, and increased PDL of medium from light. It was mentioned that at the time of the injury, the patient was working as a supervisor with a required PDL of 100+. His vocational plan was to return to work as a consulter/contractor, with a required PDL of heavy. The provider stated that the program had exerted a positive impact on the patient's symptoms; however, he has not met the targeted reduction of 75 percent in every active symptom. He required an additional 80 hours/units in order to extinguish active symptoms over a long-term basis, maximize functional tolerances, and propel her towards a safe return to work. Medications at that time included gabapentin 300 mg QTD, Naprosyn 500 mg daily, lisinopril-hydrochlorothiazide, metformin and Zocor. The total number of CPMP hours completed to date needs to be clarified. It appears from the records that the patient may have completed a total of 160 hours of CPMP. The note dated April 25, 2014, stated that the patient had completed 80 hours of CPM at this time and succeeding records indicated that another 80 hours have been authorized. In addition, the most recent evaluation did not reveal significant improvement from the recently completed chronic pain program. The patient's psychological scores have increased (instead of improving) while his PDL has only increased from Light/Light-Medium to Medium. The referenced guidelines state that for a patient that has been continuously disabled for greater than 24 months, there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. The patient's reported date of injury was xx/xx/xx, and his target PDL is heavy. I discussed the case who did not have any additional clinical information available to support this request. With these reasons, the medical necessity of the requested 80 hours of Chronic Pain Management Program is not established in agreement with the previous determination."

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

Patient has multiple factors contributing to pain, but has shown minimal improvement following a Chronic Pain Program. Thus, the ODG criteria for continued treatment in a chronic pain program has not been met.

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

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