

Notice of Independent Review Decision

**September 17, 2015**

**IRO CASE #:**

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

Chronic pain management program – 80 hours (97799 – CP)

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

Physical Medicine and Rehabilitation Physician

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work-related injury on xx/xx/xx, while working. The patient was going to the restroom when she slipped and fell backwards. She started having back pain.

evaluated the patient on July 9, 2015, for the work-related injury. The patient stated due to the incident she started having back pain. She initially went to where she underwent x-rays and was prescribed medications. The patient then went to and was prescribed pain medications. this was followed by a course of physical therapy (PT). The patient then had one lumbar epidural steroid injection (ESI), which did not help with the back pain. The patient underwent electrodiagnostic studies on February 17, 2015, which showed asymmetrical sensory peripheral neuropathy, mild right and moderate left L4-S1 lumbar radiculopathy, L5 nerve root level involvement. In April 2015, the patient had lumbar surgery and attended postsurgical therapy. examination of the lumbar spine

revealed a well-healed surgical incision, tenderness of the lumbar paraspinals bilaterally, restricted range of motion (ROM) and decreased sensation in the left lower extremity. Kemp's test provoked low back pain. the diagnoses were lumbar radiculitis, herniated nucleus pulposus (HNP) of the lumbar spine and lumbar sprain/strain. the patient was given referral for mental health evaluation (MHE), functional capacity evaluation (FCE). Prescription was given for Elavil, clonazepam, Norco and Zanaflex. The patient was determined to be temporarily disabled pending MHE and FCE.

The patient underwent a behavioral evaluation on July 13, 2015. The patient rated her average pain level of 8. On the Beck Depression Inventory (BDI), the patient scored 29 indicating moderate range of depression. On the Beck Anxiety Inventory (BAI), she scored 29 indicating moderate range of anxiety. Global Assessment of Functioning (GAF) was 65. It was noted till date, the patient's treatment had included physical therapy (PT), transcutaneous electrical nerve stimulation (TENS) unit, warm/cold compresses, steroid injection, surgery, pain management and medical supportive care. It was recommended that the patient's symptoms of depression and anxiety continue to be monitored and reviewed by a medical consult. The patient should participate in 80 hours of a chronic pain management program (CPMP).

In a work capacity evaluation dated July 13, 2015, the patient demonstrated maximum effort.

On July 22, 2015, made a pre-authorization request for CPMP for 80 hours to address the psychological component of her injury. The patient was currently taking Norco, Zanaflex, ibuprofen and Elavil. The patient did not have adequate pain and stress management skills. She needed a specific pain and stress management training to be more functional while dealing with pain on a daily basis.

According to a Utilization Review dated July 27, 2015, the request for CPMP x 80 hours. Rationale: *"During the peer conversation, the case was discussed with regard to the provided medical records, guidelines and requests with no additional information provided. In this case, on 12/15/14, the patient was seen in a designated doctor examination and released to return to work at light duty. On 1/14/15, the patient returned to work on light duty. On 7/13/15, it was stated that the patient was working modified duty. The patient is said to be at a sedentary physical demand level. he measured strength is unrealistically poor. The arm lift is 4.3 pounds; leg lift is 11.5 pounds, etc. Force/time curves do not show the typical morphology associated with a full effort. The patient works as a dispatcher. This is said to require a medium physical demand level. It is unclear what duties merit a medium physical demand level. Job duties of a dispatcher were not described. The patient is said to be quite depressed. It is unclear whether the patient has had an adequate trial of antidepressants. It is unclear whether the patient has exhausted all other conventional care. Strength testing suggests poor effort. Given that the patient has returned to work, a return to work program is not reasonable. Therefore, the request for chronic pain management program times 80 hours is neither medically necessary nor appropriate. "*

On July 28, 2015, requested reconsideration of CPMP for 80 hours. He stated the patient required the medical services that were available in a CPMP in order to address the psychological

component of her injury, achieve clinical MMI, returning to gainful employment and to achieve case resolution.

According to a subsequent medical report dated August 6, 2015, noted the patient had ongoing back pain and numbness of the left foot. She ambulated with a cane. Examination of the lumbar spine showed tenderness of the lumbar paraspinals bilaterally, restricted lumbar ROM and decreased sensation of the left lower extremity. The patient was prescribed Elavil, clonazepam, tizanidine, Ultracet and Cymbalta.

According to a utilization review dated August 20, 2015, the request for CPMP x 80 hours was non-certified. Rationale: *“The initial request was non-certified noting that on 12/15/14, the patient was seen in a designated doctor examination and released to return to work at light duty on 1/14/15. On 7/13/15, it was stated that the patient was working modified duty. The patient was said to be at a sedentary physical demand level. The measured strength is unrealistically poor. The arm lift is 4.3 pounds, leg lift was 11.5 pounds. Force and time curves do not show the typical morphology associated with a full effort. The patient works as a dispatcher. This was said to require a medium physical demand level. It is unclear what duties merit a medium physical demand level. The job duties of a dispatcher were not described. The patient was said to be quite depressed. It was unclear whether the patient had an adequate trial of antidepressants. It was unclear whether the patient has exhausted all other conventional care. Given that the patient had returned to work, a return to work program is not reasonable. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient's subjective complaints appear to outweigh objective findings. The patient has not shown any significant improvement with lower levels of care and would not likely benefit from a more extensive program such as a chronic pain management program. During the peer discussion, the case was discussed in detail and no additional information was added. Thus, the request is not medically necessary or appropriate.”*

On an unknown date (stamp date 08/31/15), the patient underwent an individual counseling session. The patient reported a pain level of 7 in a scale of 1-10. It was noted the patient was a mother of five children. Her husband recently left, immediately after her surgery. The patient ambulated with a cane and feared falling without it.

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

**Based upon the available documentation claimant is currently undergoing psychological counselling, and recent addition of medication Cymbalta with no indications in recent treatment notes that this new treatment plan has failed. Also I do not appreciate in the psychological assessment that ODG guidelines criteria including “There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware**

**that successful treatment may change compensation and/or other secondary gains.”  
has been established.**

**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**