

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 10 Sessions

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

This physician is a Board Certified Physical Medicine and Rehabilitation Physician with 14 years of experience.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx, an MRI of the lumbar spine was performed. Impression: 1. Degenerative disk disease with partial disc desiccation at L4-5 and L5-S1. 2. A

4-5 mm central and left central disc protrusion at the L5-S1 level with disc material compressing and slightly displacing the traversing left S1 nerve root posterolaterally. Disc material abuts, but does not clearly compress or displace the traversing S1 nerve root on the right. The traverse extent of the protrusion exceeds 1 cm. 3. Asymmetric foraminal and far lateral disc bulge or small protrusion on the left at L4-5 with minimal foraminal encroachment. No obvious mass effect on the exiting left L4 nerve root. There is bilaterally facet hypertrophy and mild ligamentum flavum hypertrophy, and the combination of findings produces mild central spinal stenosis at this level. There may be just minimal lateral recess stenosis superiorly at L5 on the left. 4. No compression fracture of spondylolisthesis. No marrow replacement as interpreted by M.D.

On March 31, 2003, an EMG/NCS was performed. Impression: 1. Upper extremity sampling demonstrated changes consistent with brachial plexopathy/brachial plexus stretch injury on the left side without acute changes and with no evidence of acute cervical radiculopathy or compressive neuropathy. 2. No thoracic radiculopathy was identified, but there is an indication of mild lower sacral S2-S4 motor root dysfunction, left greater than right, consistent with his clinical symptoms. 3. There is indication of acute irritability in the bilateral L4, L5 and S1 motor roots with moderate reductions in pattern being most involved in the left L5 distribution. This is confirmed by delays of the right and left peroneal F-waves as interpreted by M.D.

On August 10, 2004, x-rays of the lumbar spine show lower lumbar spine postoperative changes with posterolateral fusion L4 through S1 with orthopedic plates and pedicular screws through the bodies of L3-L5 as interpreted by M.D.

On December 2, 2004, the claimant was evaluated by M.D. He complains of pain described as aching, sharp, tender, numb, tingling and unbearable most of the time. He describes numbness and tingling into both arms and legs. He does have problems with impotency. DTRs are bilaterally present at the patella but somewhat diminished on the left as compared to the right. The claimant has a positive SLR at 30 degrees on the left and 45 degrees on the right. Impression: Status post decompression and arthrodesis with transpedicular fixation L4-5 and L5-S1. Bone growth stimulator insertion. 2. Radiculopathy, clinical, lumbar spine. 3. Spondylosis L2-3 and L3-4. 4. Loosening of screws, L4. 5. Instability L3-4.

On December 21, 2004, an EMG/NCS was performed. Impression: Indication of acute irritability in the bilateral L4 through S1 motor roots with no involvement of the L3 motor root 2 distributions. This is similar to the previous study, though with a slightly greater pattern reduction in all three root levels, particularly on the left. 2. There is a slightly greater reduction in the lower sacral, S2-S4 motor roots based in external anal sphincter sampling than on the previous study consistent with his increase in incontinence as interpreted by M.D.

On January 7, 2005, a lumbar CT/myelogram was performed. Impression: Postoperative changes at the L4-5 and L5-S1 levels with some epidural scarring. Slight annular bulging at the L3-4 level as interpreted by M.D.

On January 31, 2005, M.D. evaluated the claimant. Physical Examination: DTRs are bilaterally present at the patella but somewhat diminished on the left as compared to the right. The claimant has a positive SLR at approximately 30 degrees on the left and 45 degrees on the right.

On August 12, 2005, M.D. performed a facet block with fluoroscopic guidance as L3-4 and L5-S1.

On August 30, 2005, the claimant was re-evaluated by M.D. His pain decreased 100% for three to four days, but now he has pain and some spasm in his low back. No EHL weakness is noted. Positive SLR on the left at 45 degrees, on the right 60 degrees.

On September 29, 2005, M.D., a neurologist, placed the claimant at statutory MMI as of December 1, 2004 with a 24% whole person impairment.

On February 3, 2006, the claimant was re-evaluated by M.D. Flexion is 60 degrees, extension is 10 degrees. Motor strength is 5/5. DTR Achilles tendon and patellar are $\frac{1}{4}$. Positive right lower extremity straight leg raise and paraesthesias extending into his foot. Negative left lower extremity SLR.

On May 30, 2006, the claimant underwent surgical intervention of the lumbar spine as performed by M.D. Procedures: 1. Removal of posterior spinal hardware. 2. Removal of implanted bone growth stimulator. 3. Exploration of posterior spinal fusion mass. 4. Posterior spinal fusion L5-S1 with BMP and locally harvested autograft bone. 5. Augmentation of L4-5 posterolateral fusion with BMP and locally harvested autograft bone. 6. Bilateral Lt5-S1 foraminotomies. 7. Neurolysis of bilateral L5 and S1 nerve roots. 8. Decompression of bilateral L5 and S1 nerve roots. 9. Placement of medium Hernovac drain.

On June 8, 2006, the claimant was seen for a post-operative evaluation by M.D. He has an aching, occasionally sharp and burning pain in his back which is alleviated if he gets up and walks.

On June 29, 2006, the claimant was seen for a post-operative evaluation by M.D. He has had several episodes of night sweats. He does not use a cane or walker to ambulate, however he does use lumbosacral support brace. He is to start aquatic therapy.

On October 31, 2006, the claimant was re-evaluated by M.D. He has not yet had any post operative physical therapy. He complained of nagging, sharp, tingling, numbing pain in his low back and left elbow. He is currently taking Ultracet one to two p.o. b.i.d. He was prescribed Toradol 60 mg, Relafen 500 mg, Hydrocodone 5/500 mg, and Skelaxin 800 mg. DTRs are diminished at the Achilles and the patella on the left as compared to the right. The claimant sits with a mild tripod sign and has a positive seated SLR at full extension on the left and negative on the right.

On February 27, 2007, the claimant was re-evaluated by M.D. He continues to have low back pain with numbness and tingling down his legs and worsened pain in the right elbow. Diminished Achilles and patellar reflexes on the left.

On January 22, 2009, the claimant was re-evaluated by M.D. He has not been seen since February 27, 2007. Dr. pain management, released him October 2008. He has continued back pain which radiates to the lateral aspect of his left leg down the heel. He is still having problems with impotency. He wears a Comfalign LSO brace. His Ultracet and Soma prescriptions were refilled. X-rays revealed consolidation of the lateral arthrodesis L4 to S1. Spondylotic changes throughout the lumbar spine manifested by rim lesions and mild to moderate facet hypertrophy.

On April 28, 2009, a CT of the abdomen was performed. Impression: 1. Two tiny 4 mm left hemipelvic calcifications projecting through the expected location of the left ureter. These are suspicious for intraureteral calculi in light of the prior IVP findings, and clinical hematuria. Differential would include tiny periureteral phleboliths. No ureterohydronephrosis. 2. Atherosclerotic aortoiliac calcification. 3. Colonic diverticulitis. 4. Mild nonspecific global enlargement of the prostate gland as interpreted by M.D.

On November 5, 2009, the claimant was re-evaluated by Jr., M.D. He states he has done fairly well with supportive medications since his last visit. Sitting SLR is carried out past 60 degrees without evidence of tension sign.

On February 16, 2010, the claimant was re-evaluated by Jr., M.D. He is here for a follow-up post physical therapy. He continues to have lower back pain that radiates down bilaterally lower extremities with associated numbness and tingling into his heels. He is happy with his pain relief from Hydrocodone. He has significant spasm in his lower back. Mechanical test of lumbar spine reveals negative sitting SLR bilateral without root tension sign. There was hamstring tightness bilateral evident with sitting SLR. There is visible atrophy of the left calf measuring 35 cm as opposed to the right measuring 36cm. Hypoesthesia noted in the S1 dermatome bilaterally. Current Medications: Tramadol 50mg, Baxtra 250mg, and Flector Patch 12 hours.

On March 3, 2010, the claimant participated in a Functional Capacity Evaluation. Based on his functional limitations and long history of chronic pain, it is recommended his physician consider referring the claimant into a chronic pain management program to include increasing standing and walking tolerances, increase trunk and lower extremity strength.

On March 23, 2010, an EMG/NCS was performed. Impression: 1. Whereas, previously there was acute irritability in the L4 through S1 motor roots, now there is only residual; acute irritability in the L4 distributions with the right side predominating, with a greater pattern reduction than previously noted. The L5 and S1 distributions demonstrated only mild chronic residual changes with no acute irritability. 2. There is actually less involvement of the lower sacral S2-S4 motor roots than on his previous study consistent with his improvement in bladder symptoms. 3. There has been significant change on examination since his last evaluation in December of 2004 in that he now has a decreased to nearly absent right knee jerk and absent ankle jerks bilaterally whereas previously they were 2+ reflexes in the knees, trace in the right ankle, and absent in the left ankle. Also both tibial H-reflexes were obtainable in March of 2003 with the left being unresponsive in 2004, whereas now both are unresponsive as interpreted by M.D.

On June 4, 2010, the claimant underwent a diagnostic screening evaluation by M.S. Impression: He is experiencing elevated levels of avoidance and fear related to his work related injury and the impact of his pain on his current level of physical functioning. He is irritable, thinks about whether life is worth living, anxious, wonders what it would be like to never have pain, worries about his family and wonders how long this will last. His level of adjustment problems are high. Treatment should include medical interventions to decrease pain and psychological interventions to manage his pain and to increase his pain tolerance.

On July 16, 2010, an MRI of the lumbar spine was performed. Impression: 1. Status post posterior L4-S1 fusion with hardware removal. Enhancing granulation tissue surrounds the right L5 nerve root in the lateral recess at L4-5. Enhancing granulation tissue surrounds the right S1 nerve root around both L5 nerve roots at L5-S1. 2. Moderate multifactorial central spinal stenosis allowing for epidural lipomatosis. 3. Multilevel annular disc bulges and facet joint arthrosis as interpreted by M.D.

On September 22, 2010, Dr. performed 4 acupuncture treatments into the posterior aspect of the lumbar spine, right and left lower extremities and right and left auricular areas.

On September 29, 2010, Dr. performed 4 acupuncture treatments into the posterior aspect of the lumbar spine, right and left lower extremities and right and left auricular areas.

On October 6, 2010, Dr. performed 4 acupuncture treatments into the posterior aspect of the lumbar spine, right and left lower extremities and right and left auricular areas.

On November 1, 2010, Ph.D., a psychologist, performed a utilization review on the claimant. Rational for Denial: Documentation notes improvement in disability perception, fear avoidance, pain and depression with treatment. Opiate discontinuation does not require a full CPMP in this case. He is currently enrolled in college for computer science. He is at a light PDL and goal for discharge is the same, which would be high enough for a programming job, so the need for physical aspects of the program is not established. He has made progress with individual level behavioral interventions and additional treatment of that type, combined with a formal vocational rehab plan, appears to be sufficient to meet his return to work goals. Therefore, it is not certified.

On November 30, 2010, Ph.D., a psychologist, performed a utilization review on the claimant Rational for Denial: The client has had 6 sessions of psychotherapy and in that short duration there have been clear and objectified positive treatment outcomes. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, this male sustained an injury to the lumbar spine when he was working at his job, he was lifting a trashcan, emptying it into a bin using a twisting movement. On July 28, 2003, the claimant underwent a discectomy and fusion at L4-L5 and L5-S1.

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

The previous decisions are overturned. The claimant has had an extensive post-injury history with multiple procedures. An FCE demonstrated loss of function with recommendation for a chronic pain management for reconditioning. Additionally, he underwent psychological screening that demonstrated psychosocial stressors and recommendations were made for further medical and psychological treatment.

Despite individual psychological sessions with improving stressors and despite plan to return to sedentary to light work, the claimant continues on opioid medication. Furthermore, the medical records reveal that he has not attended more aggressive therapy to recondition in attempt to improve functional status. Therefore, he meets ODG criteria numbers one through ten for 10 sessions of chronic pain management program.

Per ODG:

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:

(a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program.

The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury,

underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c)

Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) 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. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration

in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. ([Keel, 1998](#)) ([Kool, 2005](#)) ([Buchner, 2006](#)) ([Kool, 2007](#)) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids](#); [Functional restoration programs](#).

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
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)