

Notice of Independent Review Decision

DATE OF REVIEW: January 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient additional chronic pain management program (CPMP) eight (8) hours per day over ten (10) days totaling eighty (80) hours as it relates to low back area.

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

This reviewer is a Board Certified Physical Medicine and Rehabilitation Physician with 15 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

There is an Employers First Report of Injury which states the claimant sustained an injury to the low back when he was.

On December 2, 2009, the claimant attended a physical therapy session, visit #1 out of 6 with Health Services for low back pain.

On December 3, 2009, the claimant attended a physical therapy session, visit #2 out of 6 with Health Services.

On December 4, 2009, the claimant attended a physical therapy session, visit #3 out of 6 with Health Services.

On December 7, 2009, the claimant attended a physical therapy session, visit #4 out of 6 with Health Services. He stated he is not seeing any change in pain levels.

On December 10, 2009, the claimant attended a physical therapy session, visit #5 out of 6 with Health Services.

On December 17, 2009, an MRI of the cervical spine was performed. Impression: 1. Minimal multilevel M/D cervical disk bulging without central spinal stenosis or neural foraminal narrowing. 2. Mild multilevel disk desiccation as interpreted by M.D.

On December 17, 2009, an MRI of the lumbar spine was performed. Impression: 1. Mild right L4 neural foraminal narrowing related to a small broad based posterolateral disc protrusion and accompanying endplate spur. 2. Mild bilateral L5 neural foraminal narrowing related to posterolateral disc bulging and facet hypertrophy as interpreted by M.D.

On December 27, 2009, the claimant presented to the emergency department at Hospital with complaints of a foul smelling left foot. Impression: 1. Diabetic foot, advanced. 2. Type 2 diabetes, uncontrolled. 3. Acute renal insufficiency. 4. Severe hyponatromia. 5. Lumbar pain post injury on the job 1 month ago. 6. Singultus, likely from gastroparesis acutely provoked by the infection in his foot.

On December 27, 2009, M.D. performed an incision and drainage, left foot, with amputation of 5th toe.

On December 31, 2009, M.D. performed a left guillotine below-the-knee amputation. Preoperative Diagnosis: Gangrene left foot.

On January 5, 2010, M.D. performed a left below-knee amputation. Preoperative Diagnosis: Gangrene left foot.

On January 16, 2010, an MRI of the brain was performed. Impression: Ventriculomegaly out of proportion to volume loss, which is suggesting of communicating hydrocephalus. Given balance problems, this could represent normal pressure hydrocephalus as interpreted by M.D. and, M.D.

On February 10, 2010, the claimant was discharged from the Institute of Rehabilitation. Physical therapy was recommended followed by outpatient 3 for 6 or as per recommendation of follow up therapist.

On March 8, 2010, the claimant was evaluated by M.D. He has complaints of phantom pain where he had BKA for diabetic foot amputation.

On April 6, 2010, the claimant was re-evaluated by, M.D. His glucose was 110. He has left arm pain specifically to the left 5th digit and lateral 5th. He has grip weakness and arm limitation. The pain in his low back travels into buttocks and goes down both legs.

On June 25, 2010, , M.D. placed the claimant at MMI as of June 25, 2010 with a 10% whole person impairment based on his lumbar spine injury based on leg atrophy (53.2 cm on left and 57.5 cm on the right).

On July 1, 2010, a Physical Performance Evaluation was performed. He could perform very little testing due to instability on his left prosthetic leg. He is severely limited once on his feet. He needs to develop strength and stability once on his feet. Work hardening was recommended.

On July 8, 2010, M.A., L.P.C. performed a psychological evaluation. Impression: 1. Chronic pain syndrome. 2. Difficulty dealing with negative emotions appropriately. 3. Distorted beliefs about the relationship between pain and disability, which can lead to withdrawal from normal and productive activities. 4. Inadequate coping skills to manage emotional stress related to changes stemming from work related injury. 5. Lifestyle which has resulted in physical deconditioning. 6. Symptoms of depression/anxiety. 7. Inability to return to work due to above problems. A work hardening program was recommended.

On July 12, 2010, the claimant began a work hardening program.

On August 5, 2010, the claimant participated in a Physical Performance Evaluation. He had a genuine effort. He is currently at a light PDL. 10 days of work hardening, program, 8 hours per day, 5 days per week for 4 weeks was recommended.

On August 13, 2010, the claimant completed his work hardening program.

On August 24, 2010, the claimant began a chronic pain management program.

On September 16, 2010, the claimant was evaluated by M.D. He complained of stiff, dull, achy, frequently sharp pain in his low back radiating posterolaterally into bilateral lower extremities, right greater than left. Prior to his injury he has a right hemilaminectomy at L4-L5 which the claimant stated he was asymptomatic prior to his injury. He underwent a lumbar ESI with no relief. He is currently on Hydrocodone 7.5/500 mg and Celebrex 200 mg. He is to continue chronic pain management with a goal of obtaining a medium PDL. Physical Examination: L4-S1 facet tenderness on the right. Positive right-sided Kemp's test. Positive facet pain on axial loading. Normal sensory exam on the right. Mild reduction in L5 motor nerve root strength on the right 4 ¾ /5. The claimant possess +1/4 deep tendon reflexes at patella bilaterally and at the Achilles on the right. There is an equivocal SLR test in the sitting position on the right. Assessment: Lumbar strain, Lumbar facet syndrome, Lumbar degenerative disc disease, and Lumbar intervertebral disc disease.

On November 5, 2010, the claimant was re-evaluated by, M.D. His pain is a 5-8 out of 10. He has clinical findings of right radiculopathy with a positive straight leg raising test on the right, a positive Bragard's with L5 motor nerve root weakness of 4.5/5. He requires a neurological evaluation. Assessment: Lumbar strain, Lumbar facet syndrome, Lumbar degenerative disc disease, Lumbar intervertebral disc disease, and Rule out lumbar radiculopathy.

On November 11, 2010, the claimant was re-evaluated by, M.D. He is now attending his 19th sessions of Chronic Pain Management out of 20. He rates his pain at 7 out of 10. He is to continue CPM. Assessment: Lumbar strain, Lumbar radiculopathy, Lumbar degenerative disc disease, and Lumbar intervertebral disc disease.

On November 18, 2010, M.D. performed a peer review. He determined that his previous impairment rating of 10% is correct; however it is clear that the previous injury contributed to the current status

On November 18, 2010, Ph.D., a psychologist, performed a utilization review on the claimant. Rationale: The claimant has completed 96 out of the 160 hours authorized for the CPMP as of 11/5/10. Progress towards goals are provided for dates of participation up to 11/5/10 and suggest that the claimant has met his goals for reducing depressive symptoms, reducing anxiety symptoms, reducing fear avoidance beliefs regarding physical activity, improving GAF, achieving medium PDL and reducing pain medications. The claimant has not met goals toward reducing fear avoidance beliefs regarding work, pain level, scores on the Pain Catastrophizing Scale, and improving sleep. Progress towards vocational goals is unclear since the claimant is currently working on "improving conducting job searches" and "identifying transferable job skills." According to Dr. on 9/16/10 "it is unreasonable to assume that he will return to TYC with the job description requiring him to restrain male youths weighting 180 pounds or greater". Therefore, it is not certified.

On November 22, 2010, L.P.C. with Rehabilitation Center requested additional 80 hours CPMP. Previous Medications: Hydrocodone 7.5/500 mg every 4 hours and Celebrex 3x per day. Current Medications: Hydrocodone 7.5/500 mg 2x per day. Mr. has completed 20 days of Chronic Pain Management with some improvements. Mr. continues to show a positive attitude towards recovery and improvement with time management skills. The claimant is displaying a good effort in the program and 100% compliance with the program. Mr. has made significant improvements since beginning pain program. He has had a decreased in both anxiety and depression symptoms since starting the program. Mr. has reached 80% of his goal in carry and from floor to knuckle. He has reached and exceeded his goal from knuckle to shoulder and from shoulder to overhead. Mr. has reached his goal in prolonged sitting of 60 minutes. He has reached 66% of his goal in prolonged standing, and 86% of his goal in prolonged walking, with the use of a cane. The claimant has met 33% of his goals on the bike and 25% of his goals on the treadmill. He has reached 50% of his goals in work simulation.

On December 15, 2010, D.O., an occupational medicine physician, performed a utilization review on the claimant. Rationale: He completed 96 hours of the authorized 160 hours for Chronic Pain Management Program through 11/5/10. He has progressed through his goals of participation, meeting goals for reducing depressive symptoms, reducing anxiety symptoms, reducing fear avoidance beliefs regarding physical activity, improving GAF, reducing pain medication, and achieving a medium physical demand level. Dr. stated on 9/16/10 "It is unreasonable to assume that he will return to the with the job description requiring him to". Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to the lumbar spine and leg when he was causing the claimant to feel a short pain in his low back and leg, and was knocked to the concrete floor.

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

The previous decisions to deny additional 80 hours of Chronic Pain Management are upheld. Per the ODG Pain Chapter #9 under Chronic Pain Management: "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.” As estimated by Dr. on 9/16/10, after 86 hours of Chronic Pain Management, the claimant has met the set functional good of Medium PDL and reduction of indices of psychosocial stress.

Per the 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)**