

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/24/11

**IRO CASE NO.:**

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

Item in dispute:

Date of Appeal Request: 05/10/2011

Procedure/Treatment: 80 hours of Chronic pain management Program

Date of Appeal Decision: 05/16/2011

Physician Reviewer & Chiropractic Medicine

Licensure & State: TX

Guideline/Criteria: ODG Treatment Guidelines

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

Texas Board Certified Anesthesiologist

Pain Medicine Fellowship

**REVIEW OUTCOME**

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

Denial Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

## **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a XX-year-old male who sustained an injury on XX/XX/XX when he tried to push a rolling object that was stuck and injured his low back.

Radiographs of the lumbar spine performed 12/21/09 demonstrated normal anatomic alignment. There were moderate degenerative endplate changes at L5-S1, to include minimal posterior osteophytes. There was moderate bilateral facet arthropathy at L5-S1.

An MRI of the lumbar spine performed 12/21/09 demonstrated a left posterolateral extruded disc herniation at L4-L5. There was mass effect on the thecal sac anterolateral and to the left. There was secondary high-grade foraminal stenosis with impingement of the exiting left L4 nerve root. The remainder of the L4-L5 disc showed a broad-based subligamentous disc protrusion. Moderate central canal stenosis was present at L4-L5. There was a broad-based subligamentous disc protrusion at L5-S1 with mild mass effect on the thecal sac.

The employee saw Dr. on 02/08/10 with complaints of low back pain with radiation into the left lower extremity rating 10 out of 10. Physical examination revealed decreased motor strength of the left lower extremity. The employee was able to toe and heel walk with difficulty. Lumbar range of motion was restricted. Kemp's test was positive bilaterally. There was tenderness to palpation of the lumbar spine. Vertebral muscle spasms are noted bilaterally at L1 through S1. The employee was assessed with herniated nucleus pulposus, lumbar radiculopathy, and myospasms. The employee was referred for pain management and orthopedic consultation.

Electrodiagnostic studies performed 02/24/10 were abnormal with evidence consistent with a lumbar radiculopathy primarily affecting the left L4 nerve root, indicated by positive sharp waves and fibrillation potentials. The employee attended nine sessions of physical therapy from 02/23/10 through 03/11/10.

The employee was seen for evaluation on 05/19/10. The employee complained of low back pain with radiation to the left lower extremity with associated numbness. The employee rated the pain at 7 to 9 out of 10. Physical examination revealed tenderness to palpation in the midline and paravertebral region. There were muscle spasms noted. Range of motion was decreased. Straight leg raise was reported to be positive. There were complaints of numbness and paresthesias of the left lower extremity. The employee was assessed with lumbar radiculopathy, lumbar herniated nucleus pulposus, left lower extremity pain and paresthesias, left lower extremity weakness, and myofascial pain and spasms. The employee was prescribed Vicoprofen, Soma, and Lyrica.

Video ENG report dated 05/24/10 demonstrated no evidence of significant peripheral or central vestibular dysfunction.

The employee saw Dr. on 06/02/10 with complaints of low back pain with radiation to the left lower extremity. Prior treatment included medications and physical therapy. The note stated the employee was unable to try epidural steroid injection due to his diabetes. Physical examination revealed limited lumbar range of motion. Straight leg raise was to 20 degrees on the left. There was Grade 4 weakness of the left tibialis anterior and Grade 3 weakness of the left extensor hallucis longus. There was reduced sensation of the left L5 dermatome. The employee was recommended for MRI of the lumbar spine.

An MRI of the lumbar spine performed 06/23/10 demonstrated no apparent disc bulge or herniation at L1-L2, L2-L3, and L3-L4. At L4-L5, a left central/left subarticular disc herniation was identified extending toward the left subarticular region. There was contact with the traversing left L5 nerve. Small facet joint effusions were present. The

neural foramina were patent. At L5-S1, there was a central disc herniation with disc space narrowing noted. The neural foramina appear narrowed at the level of the disc space bilaterally.

The employee saw Dr. on 07/14/10. Physical examination revealed limited lumbar range of motion. The employee used a cane for ambulation. There were true nerve root tension signs on the left side. Straight leg raise was reported to be positive at 25 degrees. There was Grade 4 weakness of the left tibialis anterior and Grade 3 weakness of the left extensor hallucis longus. The employee was recommended for surgical intervention.

The employee underwent left L4-L5 laminectomy and discectomy with decompression of the left L5 nerve root on 08/25/10.

The employee saw Dr. on 09/08/10. Physical examination revealed a well-healed incision. Range of motion was limited. There was back pain with straight leg raise. The employee was recommended for physical therapy.

The employee completed eighteen sessions of physical therapy from 10/18/10 through 12/03/10.

A Functional Capacity Evaluation (FCE) was performed on 12/16/10. The employee's occupation as a diesel mechanic required a very heavy physical demand level. The employee was capable of performing at a sedentary physical demand level. The employee was felt to be a good candidate for a chronic pain management program.

The employee was seen for evaluation on 01/17/11. The employee rated his pain at 7 out of 10. Physical examination revealed restricted lumbar range of motion. Kemp's test was positive. There was popping of the low back noted. The employee was recommended for a mental health evaluation.

The employee was seen for evaluation on 02/16/11. The employee complained of lumbar pain rating 8 out of 10. Physical examination revealed restricted lumbar range of motion. L5 sensory loss was noted on the left. Kemp's was positive on the left. The employee stated it felt like the bones of the low back were "rubbing on something". The employee was recommended for repeat MRI of the lumbar spine.

The employee saw Dr. on 03/14/11 with complaints of pain in the low back and left lower extremity rating 6 to 8 out of 10. Physical examination revealed tenderness to palpation of the lumbar spine and paraspinal muscles. Lumbar range of motion was decreased with pain. Lumbar facet loading was positive bilaterally. Straight leg raise was reported to be positive bilaterally. Sensation to light touch was decreased in the L4 and L5 dermatomes of the left leg. This clinical note was incomplete, and the treatment plan was not provided for review.

The employee was seen for evaluation on 04/12/11. The employee rated his pain at 8 out of 10. The employee was unable to walk for more than five minutes with the use of a cane. The employee was able to sit for no more than forty-five minutes and stand for no more than thirty minutes. Current medications include Lisinopril, Lyrica, Metformin, Simvastatin, and Ultram ER. Physical examination revealed restricted lumbar range of motion, but this was noted to be improved from the initial visit. Bilateral lateral flexion continued to be severely restricted. The reflexes were intact and bilaterally symmetrical in the upper extremities. The reflexes were diminished on the left. There was some sensory loss of the left L5 dermatome. It appeared this note was incomplete.

An FCE was performed on 04/13/11. The employee's occupation as a required a very heavy physical demand level. The employee was capable of performing at a sedentary physical demand level. A toxicology report dated 04/13/11 was positive for Tramadol and marijuana.

The employee was seen for evaluation on 04/19/11. The employee complained of lumbar pain rating 9 out of 10. Physical examination revealed restricted lumbar range of motion. Kemp's was positive on the left. The employee was recommended for chronic pain management.

The request for chronic pain management was denied by utilization review on 04/28/11 as the employee had elevated pre-treatment pain levels. There was indication that additional diagnostic testing had been considered. Given that additional diagnostic testing may be needed and given the indication of some improved range of motion on 04/12/11, the criteria was not satisfied.

The employee saw Dr. on 05/09/11 with complaints of low back pain and leg pain. The employee reported two falling episodes on 05/04/11 due to increased pain in the low back. The employee rated his current pain at 9 out of 10. Current medications included Lisinopril, Lyrica, Metformin, Oxycodone, Simvastatin, and Ultram ER. Physical examination revealed tenderness to palpation along the lumbar spine and paraspinal muscles. Lumbar range of motion was decreased with pain. Lumbar facet loading was positive bilaterally. Straight leg raise was reported to be positive bilaterally. There was mild swelling noted to the medial aspect of the left knee. There was decreased sensation to light touch of the L4 and L5 dermatomes of the left leg. The employee was assessed with post-laminectomy syndrome, lumbosacral spondylosis, and lumbar disc displacement. The employee was prescribed Ultram ER, Lyrica, and Oxycodone.

The request for chronic pain management was denied by utilization review on 05/16/11 as the employee has been in the rehabilitation program of the requesting facility and in the interim had descended into chronic pain, extreme disability, and opioid use. It was not expected that the same facility was going to successfully reverse this in chronic pain management. The records indicated the employee participated in eighteen sessions of rehabilitation, to include thirty minutes of manual therapy and ninety minutes of exercise in each session. According to the FCE, the employee was completely incapable of performing any dynamic lifts of even the smallest amount of weight. There was no explanation for this discrepancy. There was no evidence that a psychological evaluation has been performed. There were inconsistent reports of pain levels and inconsistent reports of current opioid intake.

The employee was seen for evaluation on 05/18/11. The employee complained of back pain rating 9 out of 10. Physical examination revealed restricted lumbar range of motion. There was sensory loss noted in the L5-S1 dermatome on the left. Kemp's was positive on the left. Straight leg raise was reported to be positive on the left. The employee was recommended for chronic pain management.

The employee was seen for behavioral health evaluation on 05/26/11. The employee complained of low back pain with radiation into the left leg rating 8 to 9 out of 10. Mental status examination revealed the employee's mood to be depressed with a significantly blunted affect. The employee's HAM-D score was 13, indicating a level of mild severe depression. The employee's HAM-A score was 34, indicating severe anxiety. The employee's GAF score was 50. The employee was recommended for participation in an interdisciplinary chronic pain management program.

The employee was seen for evaluation on 05/31/11. The employee rated his pain at 10 out of 10. Current medications include Lisinopril, Lyrica, Metformin, Simvastatin, and Ultram ER. Physical examination revealed restricted range of motion, but was noted to be improved from his initial visit. Lumbar flexion was to 19 degrees, extension was to 6 degrees, left lateral flexion was to 7 degrees, and right lateral flexion was to 8 degrees. Reflexes were noted to be intact and bilaterally symmetrical in the upper extremities. The reflexes were diminished in the left lower extremity. Some

sensory loss was noted of the left L5 dermatome. The employee was recommended for participation in an interdisciplinary chronic pain management program.

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

The requested chronic pain management program for ten sessions would be considered medically necessary based on the clinical documentation provided for review. The employee has attended several sessions of physical therapy that have failed to improve the employee's physical demand level. The employee has undergone two separate FCEs that both demonstrated a sedentary physical demand level. The employee was utilizing a significant amount of medications with no effect. More recently, the employee's behavioral evaluation demonstrates objective evidence of severe depression and anxiety. Given the employee's significant functional difficulties, it is unlikely that the employee will improve with lower levels of care. The employee demonstrates functional deficits and significant anxiety and depression. There are definite polypharmacy concerns that would reasonably be addressed through a chronic pain management program. There is no indication that the employee is being considered for further surgical intervention at this time. At this point, a chronic pain management program would be the employee's only course of action to address the continued chronic pain, lack of function, and medication use. As such, medical necessity is established.

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

*Official Disability Guidelines*, Pain Chapter

#### **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](#).