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Notice of Independent Review Decision

DATE OF REVIEW: 6-1-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of additional chronic pain management program 5 times per week for 2 weeks.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the additional chronic pain management program 5 times per week for 2 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Provider, Provider, and Employer

These records consist of the following:

DIAGNOSTIC STUDIES

- 2008/04/17 Cervical spine x-rays: (1) congenital partial segmentation anomaly versus surgical fusion at the C4/C5 level. (2) mild degenerative disc disease at C-5/C6.
- 2008/04/17 X-Rays Right Shoulder: no significant radiographic abnormality.
- 2008/04/17 MRI Cervical Spine without enhancement: congenital fusion of C4/C5. There is associated mild disc degenerative change seen at C3-C4, C5-C6, and C6-C7 with mild disc protrusion appreciated in a circumferential fashion. There is moderate narrowing of the right C5-C6 neural foramen present when compared to adjacent levels.
- 2008/06/17 Consultation by M.D.
- 2008/12/08 MRI of the right shoulder.
- 2009/03/05 Electrodiagnostic Studies D.O.

- 2009/05/21 Chest X-Ray, reported to be normal.
- 2009/05/21 Cervical Spine X-Rays, showing congenital fusion at C4-C5 with no evidence of fracture or dislocation.
- 2009/05/21 CT Scan of the Cervical Spine showing probable congenital fusion C4-C5, degenerative disc changes, no evidence of fracture.
- 2008/09/11 Workers compensation request for medical care.
- 2008/04/17 Associate Statement, Workers Compensation.
- Provider Progress Notes.
- 2008/05/06 Therapy Referral Form pertaining to an injury that occurred X/XX/XX
- 2008/05/06 Referral Action Request for "evaluation for cervical ESI for C5-C6 radiculopathy".
- 2008/05/19 Patient Referral Form for Interventional Pain Management.
- 0208/06/17 Consultation, M.D.
- 2008/11/20 through 2011/04/12, Clinical Records, D.C.
- 2008/12/02 Mental Health Evaluation/Treatment Request submitted by Dr..
- 2008/12/02 Diagnostic Screening Records with treatment plans/recommendations for functional restoration.
- 2008/09/12 Referral Action Request, family practice/occupational medicine, noting that epidural steroid injection had been denied because an incorrect date of injury was submitted with the request for authorization.
- 2008/12/10 Maximum Medical Improvement determination and impairment rating evaluation, D.C.
- 2008/12/16 follow-up note, M.D.
- 2009/01/05 Initial Consultation, MPAS, PA-C orthopedic clinic
- 2009/03/20 Initial Psychiatric Evaluation, handwritten.
- 2009/03/23 DWC form-73
- 2009/03/24 Orthopedic Consultation, M.D.
- 2009/04/07 through 2011/03/03, clinical notes, M.D.
- 2009/06/09 Provider, in response to denial letter and additional medical information, M.S., L.P.C.
- 2009/08/21 Initial Diagnostic Screening, Presurgical Screening, M.A.
- 2010/01/13 Treatment Progress Report, Provider
- 2010/07/06 Office Visit, M.D.
- 2010/07/07 Treatment Progress Report, Provider.
- 2010/10/28 Functional Capacity Evaluation, chiropractic clinic.
- 2010/10/28: Maximum Medical Improvement determination and impairment rating evaluation, D.C.
- 2010/11/04 Prescription: comprehensive pain management evaluation/treatment request
- 2010/11/09 Chronic Pain Management Program Individualized Daily Treatment Plan., including treatment goals and objectives.
- 2010/11/25 Response to Denial Letter, Provider, M.S., L.P.C.
- 2011/03/03 Maximum Medical Improvement determination and impairment rating evaluation, D.C.
- 2011/03/07 - 03/23 Chronic Pain Management Program Daily Group Progress Notes.
- 2011/03/29 FCE/PPE.

- 2011/03/31 Chronic Pain Management Program Treatment Goals and Objectives.
- 2011/04/17 Chronic Pain Management Program Treatment Progress Report, Provider
- 2011/04/20 Response to Denial Letter, Provider, M.S., L.P.C.
- 2011/05/11 Request for Review by an IRO.
- Undated FCE/PPE.
- Copies of forms filled out by hand, some illegible.
- Undated request for EMG/NCV of upper extremities.
- Handwritten treatment progress notes.
- DWC Forms-79

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Worker sustained a work related injury XX/XX/XXXX at company when he moved a box that slipped from his grasp. He attempted to grab the box and felt pain in the neck and right upper extremity. The injured worker was seen in consultation by Dr. XX/XX/XX. Dr. diagnosed cervicalgia and cervical herniated nucleus pulposus with foraminal stenosis. He recommended transforaminal epidural steroid injections. The injured worker was taking Neurontin and Vicodin.

Dr. saw the injured worker November 20, 2008 for initial examination regarding injuries to the cervical spine, right shoulder. On examination the left triceps reflex was decreased compared with the right. There was marked tenderness of the right cervical paraspinals. Dr. diagnosed cervical sprain-strain, right shoulder sprain-strain, and rule out cervical disc injury with radiculopathy. On December 10, 2008 Dr. found the injured worker not to be at MMI.

Dr. saw the injured worker for interventional pain management follow-up December 16, 2008. Dr. recommended transforaminal epidural steroid injections.

EMG and nerve conduction studies March 5, 2009 were interpreted to show evidence of a lower cervical motor nerve problem.

The injured worker was seen March 24, 2009 by Dr. for orthopedic evaluation and treatment. He noted that cervical spine lateral extension views showed an abnormal extension angle of 25 degrees at C5-C6 and 14 degrees at C6-C7, indicating clinical instability pattern. Dr. discussed treatment options including surgical intervention. The injured worker preferred surgical intervention.

Dr. saw the injured worker for management of medications. On August 17, 2009 Dr. referred the injured worker to Dr. for psychiatric evaluation due to ongoing depression and anxiety. On October 22, 2009 Dr. documented that pre-authorization for surgery had been denied. The appeals process was initiated. On June 9, 2010 Dr. mentioned a contested case hearing.

On July 6, 2010 Dr. noted that the patient had lost 100 pounds over the last 10 months. Physical examination revealed cervical paravertebral muscle spasm, decreased biceps and brachioradialis jerk on the right, weakness of elbow flexion and wrist extension on the right, and paresthesia in the C6 and C7 nerve root distribution on the right. Dr. recommended medical workup for an unexplained weight loss. He anticipated scheduling the patient for surgery after the evaluation is completed.

On August 11, 2010 Dr. noted that "due to the patient's inability to progress forward with surgery, the next most reasonable level of care for this patient according to the ODG will be chronic pain management program".

On October 19, 2010 the injured worker was referred for a physical performance evaluation. Dr. prescribed a chronic pain management program.

On October 28, 2010 a functional capacity evaluation determined that the injured worker was functioning at a PDL of light, whereas the job requirement is a PDL of heavy. Physical performance was pain-limited. The examiner, Dr., stated that the patient will benefit from a multidisciplinary program such as a chronic pain management program.

On March 3, 2011 the injured worker was found to be at statutory MMI with an impairment rating of 11 percent whole person impairment, of which five percent is for the DRE Category II for the cervical spine. On March 3, 2011, Dr. noted that the injured worker was always in pain. Dr. increased hydrocodone to 10 milligrams and prescribed Norco 10/325 1 qid, Lyrica 50 milligrams tid, and Cymbalta 20 milligrams bid.

The injured worker participated in a two week chronic pain management program in March 2011.

On the FCE/PPE dated 3/29/2011, the injured worker functioned at a PDL of light. According to Dr. the injured worker noted that the chronic pain management program was very helpful. Dr. prescribed an additional 10 days of chronic pain management.

On the report documented 3/31/11, after 10 days of the chronic pain management program, some improvement was reported in all areas. Some medications had been discontinued, including Dalmane, hydrocodone and naproxen. This report did not mention that Dr. had started Norco, Lyrica and Cymbalta on March 3, 2011. The global assessment of function improved somewhat. As noted on previous functional capacity evaluations, physical performance was pain-limited. On April 12, 2011 Dr. noted that the injured worker was able to increase his daily living activities with much greater function and less pain and discomfort.

The requested additional treatment was non-authorized. The denial was appealed on April 20. The denial was upheld on reconsideration April 27, 2011.

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

Based on the records submitted for review, the requested procedure is recommended at this time.

BASIS FOR THE DECISION

- The treating doctor and the consultants recommended surgical treatment of the documented unstable cervical spine. The injured worker agreed to proceed with surgery but the procedure was not authorized. It appears that the non-authorization was upheld in a contested case hearing, although it is unclear from the submitted records whether or not a hearing took place. In the final impairment rating of March 3, 2011 the diagnosis pertaining to the cervical spine was listed as DRE category II.
- A chronic pain management program was requested as the alternative treatment after the surgical option was eliminated. During the chronic pain management program the physical performance tasks were often pain-limited, with minimal change in the functional capacity measurements compared with the results of previous evaluations. As explained in a letter of appeal, the impaired physical performance was taken into account in the proposed

plan of care for the requested extension of treatment: the PDL goal was modified in accordance with the injured worker's impaired ability to participate in physical activity. Measurable progress was documented in the cognitive behavioral therapy component of the chronic pain management program. As stated in the ODG Guidelines pertaining to Neck and Upper Back (Acute & Chronic) (updated 04/07/11), regarding Cognitive behavioral rehabilitation: Recommended as an option for chronic cases. Behavioral treatment may be an effective treatment for patients with chronic neck pain.... Physical conditioning programs that incorporate a cognitive-behavioral approach reduce the number of sick days for workers with chronic neck pain when compared to usual care. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks
- (From the ODG cognitive behavioral therapy (CBT) guidelines for low back problems: With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)

- According to the ODG Treatment Integrated Treatment/Disability Duration Guidelines regarding chronic pain, updated 05/24/11, Chronic pain programs (functional restoration programs):

Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances, which have been met:

(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.

(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.

(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.

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 KNOWLEDGBASE
- 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)