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Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 24, 2011

**IRO CASE #:**

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

Outpatient Continuation in Chronic Pain Management Program of Five (5) sessions (40 hours total) (ICD 719.41, 722.10, 721.3) (CPT 97799: Modifier CP) (Dx Code: 719.41, 722.10, 721.3; CPT Code: 97799: Modifier CP)

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 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**

On August 9, 2007, there is a radiology report for a 2V Lumbar by, DO. The findings state mild curve right may be positional, no muscle spasm; there is a 1cm subluxation of L5 over S1; the posterior-inferior L5 body is irregular with indistinct margins; anterior bridging of T10 & 11; degenerative changes at T12.

On August 9, 2007, there is a radiology report for a 2V Thoracic Spine by DO. The findings state: no obvious fractures, chips or dislocations; there is anterior wedging of a lower thoracic vertebrae, the number not identified.

On September 20, 2007, there is an MRI Lumbar Spine without contrast read by MD. The impression states: compression deformity of the T12 vertebral body does not demonstrate evidence of bone marrow edema and is consistent with an old fracture; mild broad based disc protrusion at L2-L3 with mild mass effect on the ventral thecal sac and slight narrowing of the inferior aspects of both neural foramina; at the L4-L5 level there is a right central disc protrusion with mass effect on the ventral lateral thecal sac and slight narrowing of the right neural foramina; the combination of annular bulging of the discs at L5-S1 with moderate to severe facet disease and ligament flavum hypertrophy results in mild acquired spinal stenosis with bilateral foraminal narrowing.

On October 11, 2007, M.D. performed an EMG on the claimant. Impression: Subacute right L4 and L5 radiculopathy.

On November 15, 2007, M.D. performed Right L4 and right L5 transforaminal ESI.

On January 11, 2008, M.D. performed Right L4 and right L5 transforaminal ESI.

On February 11, 2008, MR Scan of the Right Shoulder was performed, read by M.D. Impression: Degenerative changes of the AC Joint. Abnormal increased signal intensity of the supraspinatus tendon consistent with a partial tear approaching 50%.

On April 3, 2008, Disography was performed at L3-4 and L4-5. Findings: The L3-4 discogram showed normal central nuclear accumulation of contrast. The L4-5 discogram showed diffused annular degeneration with right anterolateral and posterior annular extravasation.

On April 4, 2008, CT Scan of the Lumbar Spine. Diagnosis: At L3-4, moderate degeneration. No evidence of annular tearing. Mild central canal stenosis. No foraminal stenosis. At L4-5 there is marked degeneration. There is nuclear opacification with diffuse annular degeneration and tearing. Moderate central canal stenosis. At L5-S1, there is a grade 1 spondylolisthesis of L5 on S1. There is a moderate to marked hypertrophic central canal stenosis secondary to

thickening of the ligamentum flava and marked bilateral facet arthropathy, mild bilateral foraminal stenosis.

On September 2, 2009, D.C. evaluated the claimant. Diagnosis: Right shoulder internal derangement syndrome. Lumbar radiculitis. Lumbar HNP.

On November 9, 2009, MRI Lumbar Spine was performed read by M.D. Impression: Broad-based herniation at L2-3. Probable contact with the traversing right L3 nerve. Circumferential disc bulge at L4-5. Probable disc bulge at L5-S1. Minimal grade I spondulolisthesis at L4-5 with L5 anterior respect to L5 by approximately 4 to 5 mm.

On April 21, 2010, M.D., a PM&R physician, evaluated the claimant. Physical Examination: Lumbar spasms are noted. ROM is limited. SLR was positive bilaterally. Sensory deficits were seen in the areas of distribution of L4, L5, and S1. Motor assessment revealed slight weakness on the right 4/5. Impression: Lumbar nerve root irritation. Lumbar facet arthropathy. Right shoulder internal derangement syndrome. Myofacial pain and spasms.

On May 19, 2010, M.D., a PM&R physician, evaluated the claimant. Physical Examination: Lumbar spasms are noted. ROM is limited. SLR was positive bilaterally. Sensory deficits were seen in the areas of distribution of L4, L5, and S1. Motor assessment revealed slight weakness on the right 4/5. Impression: Low Back Pain. Right shoulder internal derangement syndrome. Myofacial pain and spasms.

On May 28, 2010, M.D. performed a Lumbar facet joint injections at bilateral L4-5.

On July 12, 2010, M.D., an orthopedic surgeon, evaluated the claimant. Diagnosis: Rotator cuff tear right shoulder. Impingement right shoulder. AC joint arthropathy right shoulder.

On July 29, 2010, M.D. performed a right shoulder intraarticular steroid injection.

On December 14, 2010, Ph.D. performed a psychological examination on the claimant. Impression: Pain Disorder.

On January 11, 2011, FCE was performed on the claimant. Claimant tested in the frequent sedentary and occasional light PDL. His occupation requires very-heavy PDL as a.

On March 8, 2011, FCE was performed on the claimant. Claimant tested in the frequent light and occasional medium PDL.

On April 4, 2011 there is documentation from, Inc. to Healthcare. The explanation of findings states: according to the submitted medial record, the claimant does not satisfy the criteria of the ODG Treatment Index for additional chronic pain management sessions. In

particular there is no evidence of significant demonstrated efficacy as documented by subjective and objective gains. The functional capacity evaluation on 3/8/11 is not compared to earlier such evaluations, and there is no evidence of increased function or decreased use of pain medication during the period of treatment. Furthermore, it appears that he has undergone 20 full-day sessions of the chronic pain management program, which is the maximum allowed duration according to the ODG Treatment Index, absent a clear rationale for the specified extension and reasonable goals to be achieved. Based on the ODG Treatment Index, the additional 5 sessions of the chronic pain management program are not considered medically necessary.

On April 12, 2011 there is documentation from, Inc. to Healthcare. The explanation of findings states: according to the submitted medial record, the claimant does not satisfy the criteria of the ODG Treatment Index for additional chronic pain management sessions. In particular there is no evidence of significant demonstrated efficacy as documented by subjective and objective gains. The functional capacity evaluation on 3/8/11 is not compared to earlier such evaluations, and there is no evidence of increased function or decreased use of pain medication during the period of treatment. Furthermore, it appears that he has undergone 20 full-day sessions of the chronic pain management program, which is the maximum allowed duration according to the ODG Treatment Index, absent a clear rationale for the specified extension and reasonable goals to be achieved. Based on the ODG Treatment Index, the additional 40 hours of the chronic pain management program are not considered medically necessary.

On April 25, 2011 there is documentation from, Inc. to Susan Demand, Healthcare. The conclusion/decision to not certify states: based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, the request reconsideration of continuation in an outpatient chronic pain management program of five sessions (40 hours) is not medically necessary at this time. As the documentation submitted is insufficient to show the necessity for outpatient continuation in a chronic pain management program of 5 sessions (40 hours), the request is not medically necessary at this time.

On April 26, 2011 there is documentation from Utilization Review, Denial for Requested Services to MD. The documentation submitted for review indicates that the patient has completed 20 sessions of a chronic pain management program. The explanation given for the request is that the patient suffered an illness while participating in the program that required that he withdraw, causing a gap in his treatment. However, as detailed previously the patient did complete 20 sessions and the documentation submitted for review indicates that the patient did have functional improvements with regard to range of motion, strength, and an increase in the patient's physical demand level. Notes also indicate that the patient had a reduction in his BDI-II score, BAI score, and his FABQ-PA scores. It would appear that the patient received good affect from the previous 20 sessions of the chronic pain management program. Also, the documentation submitted for review is insufficient to detail a clear rationale

for an extension of treatment. As such, the request reconsideration of continuation in an outpatient chronic pain management program of five sessions (40 hours) is not medically necessary at this time. The Conclusion/Decision to Not Certify: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, the request reconsideration of continuation in an outpatient chronic pain management program of five sessions (40 hours) is not medically necessary at this time. As the documentation submitted is insufficient to show the necessity for outpatient continuation in a chronic pain management program of 5 sessions (40 hours), the request is not medically necessary at this time. Reference used in support of decision: ODG, Pain Chapter Criteria for the general use of multidisciplinary pain management programs.

### **PATIENT CLINICAL HISTORY:**

The claimant was employed as a xx.

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

Per the ODG Pain Chapter under Chronic Pain Management #12 Total treatment duration should generally not exceed 20 full days (160 hours) sessions. There is no clear rationale for the specified extension and reasonable goals to be achieved. Therefore based on the above mentioned the previous decisions are upheld.

### **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)