

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 05/10/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic Pain Management Program After Care Program 24 hours (1x month for 6 months for 4 hours per session)

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he fell off a ladder, landing on his back. It should be noted that a majority of the clinical notes are difficult to interpret due to poor copy quality.

An MRI of the cervical spine performed 02/22/10 demonstrated a shallow protrusion on the midline at C2-C3. There was slight asymmetric right foraminal narrowing, but there was no stenosis. At C3-C4, there was broad-based protruding disc material into the ventral canal left of midline. The foramina were patent bilaterally. At C4-C5, there was minor posterior spondylosis and minimal midline protrusion. At C5-C6, there was minimal disc bulging concentrically. There was asymmetric left foraminal narrowing. This appeared to be on the basis of uncinata and facet hypertrophy. At C6-C7, there was disc bulging into the ventral epidural canal. There was central narrowing of the canal. There was asymmetric protruding disc material into the right neuroforamen. The left foramen was narrowed, but showed no protruding disc material. An MRI of the thoracic spine performed 02/22/10 demonstrated no acute abnormality. An MRI of the lumbar spine performed 02/22/10 demonstrated facet arthropathic changes with mild hypertrophy noted at L2-L3. There was no significant disc bulging or focal herniation of disc material. At L3-L4, there was diffuse disc bulging and a midline protrusion. There was facet arthropathy and mild hypertrophy. At L4-L5, there was disc bulging diffusely and relatively concentrically. There was a superimposed midline and

right paramedian protrusion of disc material. There was facet arthropathy, but not hypertrophy. At L5-S1, there was minimal concentric disc bulging. The canal and foramen were patent. There was facet arthropathy and mild hypertrophy.

The employee saw Dr. on 04/12/10 with complaints of stabbing pain in the upper back and sharp constant pain in the low back. Physical examination revealed moderate tenderness of the C7 spinous processes, paraspinals, and trapezius. Spurling's was negative bilaterally. There was moderate to severe tenderness of the T1-T12 facet joints and paraspinals. Paraspinal spasm was present. There was mild to moderate tenderness of the left L5-S1 paraspinals. Straight leg raise was positive bilaterally. Sensation was decreased at the right C7 dermatome. The employee was assessed with cervical sprain, head injury, post-concussion syndrome, lumbar sprain, and thoracic disc injury. The employee was referred for orthopedic consultation.

The employee saw Dr. on 04/14/10 with complaints of headaches, neck pain, and low back pain rating 4 out of 10. Physical examination revealed tenderness and muscle spasm of the cervical spine, thoracic spine, and lumbar spine. Cervical range of motion was decreased by 15%. Lumbar range of motion was good in all planes. Straight leg raise was to 90 degrees bilaterally. There was decreased sensation in the right upper extremity in a C8 distribution. The employee was assessed with chronic neck pain, cervical disc displacement, cervical radiculopathy, cervicogenic headaches, post-concussive syndrome, chronic low back pain, and lumbar facet syndrome. The employee was recommended for cervical epidural steroid injections.

The employee was seen for behavioral medicine evaluation on 04/15/10. The employee's BDI score was 23 indicating moderate depression. The employee's BAI score was 15 indicating mild to moderate anxiety. The employee was recommended for six sessions of individual psychotherapy.

Electrodiagnostic studies performed 05/06/10 were normal without evidence of neuropathy, plexopathy, or radiculopathy.

The employee was seen for Designated Doctor Evaluation on 05/19/10. Physical examination revealed muscle spasm of the cervical and thoracic spine. Cervical range of motion revealed flexion to 40 degrees, extension to 48 degrees, right lateral flexion to 30 degrees, left lateral flexion to 40 degrees, right rotation to 60 degrees, and left rotation to 70 degrees. There was spasm noted of the trapezius bilaterally. Spurling's was negative. Phalen's and Tinel's were negative bilaterally. Straight leg raise was negative bilaterally. Sensation was intact. Lumbar range of motion revealed flexion to 42 degrees, extension to 20 degrees, right lateral flexion to 18 degrees, and left lateral flexion to 20 degrees. The employee was assessed with cervical disc disruption, thoracic sprain, and lumbar disc disruption. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

The employee saw Dr. on 07/07/10 with complaints of neck pain with radiation into the right upper extremity rating 4 to 5 out of 10. Physical examination revealed cervical paraspinous tenderness. There was sensory deficit in the right upper extremity in a C8 distribution. There was lumbar paraspinous tenderness and positive facet rocking on the left. There was tenderness over the upper thoracic paraspinous region. The employee was assessed with chronic neck pain, cervical disc displacement, chronic low back pain, lumbar facet syndrome, and post-concussive syndrome. The employee was recommended for cervical epidural steroid injection.

A Functional Capacity Evaluation (FCE) was performed on 07/07/10. The employee's occupation as a required a medium physical demand level. The employee was capable of performing at a light physical demand level.

An FCE was performed on 08/18/10. The note stated the employee had completed five sessions of chronic pain management. The employee was capable of performing at a light physical demand level. The employee was recommended for additional chronic pain management sessions.

The employee was seen for Designated Doctor Evaluation on 09/01/10. The employee complained of neck pain, back pain, and headache rating 4 out of 10. Physical examination revealed muscle spasm of the left trapezius. There was decreased range of motion of the cervical spine. The employee was assessed with cervical disc disruption, lumbar disc disruption, and thoracic sprain. The employee was not placed at MMI at that time.

The employee saw Dr. on 09/08/10 with complaints of pain in the neck upper back, and low back with numbness in the upper extremities. The note stated the employee had completed five sessions of chronic pain management. Physical examination revealed moderate tenderness to palpation of the left C7 paraspinals. Spurling's was negative bilaterally. There was moderate to severe tenderness at the T1-T12 facet joints. Spasm was present. There was mild to moderate tenderness of the left L5-S1 paraspinals. Trigger points were palpable. Straight leg raise was positive bilaterally. Sensation was decreased at the right C7 dermatome. The employee was prescribed Darvocet N-100, Zanaflex, and Topamax.

An FCE was performed on 11/01/10. The note stated the employee had completed ten sessions of chronic pain management. The employee was capable of performing at a light to light-medium physical demand level. The employee was recommended for additional sessions of chronic pain management.

The employee saw Dr. on 11/10/10 with complaints of neck and low back pain rating 4 to 5 out of 10. The employee reported numbness and tingling in the upper extremities. Physical examination revealed cervical paraspinal tenderness. There was sensory deficit in the right upper extremity. There was tenderness over the lumbosacral facets from L4 through S1. Facet rocking was positive on the left. The employee was assessed with chronic low back pain and lumbar facet syndrome. The employee was recommended for lumbosacral facet medial branch blocks.

The employee saw Dr. on 12/13/10 with complaints of headaches, cervical pain, and lumbar pain. Current medications included Darvocet N-100, Zanaflex, Axert, and Topamax. Physical examination revealed no atrophy, fasciculation, or dystrophic changes. Deep tendon reflexes were 2+ and symmetric throughout. The employee ambulated without difficulty. The employee was assessed with posttraumatic acceleration/deceleration injury, mild post-concussion syndrome, posttraumatic cervical disc disease, and posttraumatic lumbar disc bulge. The employee was prescribed Elavil. The employee was referred for neurosurgical evaluation.

The employee saw Dr. on 12/30/10 with complaints of mild neck pain and headaches. Physical examination revealed the employee was able to walk on his heels and toes. There was moderate tenderness to palpation of the left C7 paraspinals. Spurling's was negative bilaterally. There was mild to moderate tenderness to palpation of the left L5-S1 paraspinals. Straight leg raise was positive bilaterally. There was full strength throughout. Sensation was decreased at the right C7 dermatome. The employee was recommended for cervical epidural steroid injection.

An FCE was performed on 01/10/11. The employee was capable of performing at a light-medium physical demand level. The note stated the employee had made progress from participation in the chronic pain management program, and an aftercare of this program was recommended to maintain and/or improve his current functional level.

The employee was seen for a Designated Doctor Evaluation on 01/17/11. The employee complained of neck and back pain rating 2 to 3 out of 10. The employee denied bowel or bladder dysfunction. Prior treatment included psychological therapy, massage, electrical stimulation, work conditioning, and multidisciplinary pain management. Physical examination revealed muscle spasm in the cervical spine. Cervical range of motion revealed flexion to 45 degrees, extension to 40 degrees, right lateral flexion to 40 degrees, left lateral flexion to 80 degrees, right rotation to 70 degrees, and left rotation to 68 degrees. There was muscle spasm noted to palpation of

the trapezius. Sensation was intact. Straight leg raise was negative bilaterally. Lumbar range of motion revealed flexion to 45 degrees, extension to 20 degrees, right lateral flexion to 25 degrees, and left lateral flexion to 25 degrees. The employee was assessed with cervical disc disruption, lumbar disc disruption, and post-concussion syndrome. The employee was placed at MMI and assigned a 10% whole person impairment.

The employee was seen for behavioral medicine evaluation on 01/25/11. This clinical note was very difficult to interpret due to poor copy quality. The note stated the employee had been feeling better since going through pain management. Current medications included Tramadol and Elavil. The employee's BDI score was 20, indicating moderate depression. The employee's BAI score was 15, indicating mild anxiety. The note stated in order to solidify treatment gains and prevent further erosion of emotional functioning, chronic pain management aftercare was recommended.

A team conference note dated 01/31/11 stated the employee had completed fourteen sessions of chronic pain management to date. The employee had been recommended for facet blocks.

The request for chronic Pain Management Program After Care Program 24 hours (1x month for 6 months for 4 hours per session) was denied by utilization review on 02/14/11. The employee completed an interdisciplinary chronic pain management program in December, 2010. Per current evidence-based guidelines, re-enrollment in a same or similar rehabilitation program was not medically warranted.

The employee saw Dr. on 02/17/11 with complaints of pain in the neck and back, as well as headaches. Physical examination revealed moderate pain to palpation of the C7 left paraspinals. Spurling's was negative bilaterally. There was no tenderness to palpation of the thoracic spine. There was tenderness to palpation of the left L5-S1 paraspinals. Straight leg raise was positive bilaterally. There was full strength throughout. The employee was recommended for cervical epidural steroid injection. The employee was referred for neurological consultation.

An MRI of the brain performed 02/18/11 demonstrated no intracranial mass, hemorrhage, infarct, or hydrocephalus. There was no abnormal signal seen. There was no abnormal intracranial enhancement.

The employee underwent L4 and L5 bilateral lumbosacral facet medial branch blocks on 02/23/11. The employee saw Dr. on 03/01/11. Physical examination revealed good comprehension and fluent speech. The pupils were equal and reactive to light. The extraocular movements are full. The employee was assessed with posttraumatic acceleration/deceleration injury, mild post-concussion syndrome, posttraumatic cervical disc disease, and posttraumatic lumbar disc bulge. The note stated the employee had reached MMI from a neurologic standpoint. The employee was returned to work without restrictions, and continued on Ultram.

The request for Chronic Pain Management Program After Care Program 24 hours (1x month for 6 months for 4 hours per session) was denied by utilization review on 03/07/11. There was documentation that the employee had completed a pain management program and a rationale for an aftercare program. However, evidence-based guidelines did not support re-enrollments in a same or similar rehabilitation program.

The employee saw Dr. on 03/23/11. The employee reported 100% relief for two to three days following the medial branch block. The employee currently rated his pain at 2 to 4 out of 10. Physical examination revealed tenderness of the lumbosacral facets from L4 through S1. There was positive facet rocking. Range of motion was improved by 5%. There are no motor or sensory deficits. The employee was recommended for facet rhizotomy and advance physical therapy as tolerated.

The employee underwent L4 and L5 left lumbosacral facet rhizotomy on 04/06/11.

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

The requested chronic pain management program after care program for 6 months at 4 hours per session is not recommended at medically necessary. To date the employee has completed fourteen sessions of a chronic pain management program. There is no clear indication of the employee's response to this program and the employee has been placed at MMI. There is limited rationale provided regarding the medical need for an aftercare program, and it is unclear what functional benefits are expected from this program. Current evidence-based guidelines do not recommend re-enrollment in similar pain management programs, and without clear exceptional factors identified by the clinical notes, medical necessity is not established.

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

Official Disability Guidelines, Online Version, 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 examination 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](#).