

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 11, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5x2 for lumbar

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

This physician is Board Certified 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 June 15, 2008, CT scan of the abdomen and pelvis interpreted by, MD.
Impression: Probable-uterine fibroids. No evidence of acute abdominal or pelvic pathology. Appendix within normal limits.

On June 24, 2008, the claimant was evaluated by DC for lower back pain, middle back pain, and abdominal pain. He noted she first sought treatment at Hospital where a CT scan was ordered. Dr. order thoracic and lumbar films which showed no evidence of acute fracture, dislocation, vertebral body compression, or spondylolisthesis. Bony mineralization was adequate. Vertebral body alignment was within normal limits. Disc spacing was relatively well maintained. Thoracic spine demonstrated mild right lateral listing in the upper aspects. There were surgical clips in the right upper quadrant. The thoracic kyphosis was maintained. Lumbar spine demonstrated surgical clips anterior to the L2-L3 disc space. There were five lumbar vertebrae. Lumbar pedicles were clearly intact. Bilateral SIJs were unremarkable. Diagnosis: Lumbar intervertebral disc syndrome with left radiculitis versus radiculopathy, lumbar zygapophyseal joint irritation and inflammation with myofascial pain and spasm, thoracic sprain/strain with myofascial spasm and trigger points, bilateral sacroilitis, left greater than right, and abdominal pain. Plan: DO for medical second opinion and consideration of medication changes, recommendation for a physical medicine and rehabilitation program, and possibly a lumbar MRI.

On June 25, 2008, the claimant was evaluated by DO. Diagnosis: Thoracic strain/sprain and lumbar strain/sprain.

June 25, 2008 – February 2, 2010, there was an extreme amount of Daily Treatment notes from Clinic by Dr. during this time frame.

On July 14, 2008, the claimant was evaluated by MD. Diagnosis: Lumbar sprain/strain, thoracic sprain/strain, lumbar radiculitis. Recommendations: MRI of the thoracolumbar spine and continuation of therapy. Prescription for Flexeril.

On July 18, 2008, MRI of the lumbar spine interpreted by, MD. Impression: 1. L1-2 through L4-5: Normal. 2. L5-S1: 2 mm right paracentral protrusion with a zone of hyperintensity, suggesting that the disc is acutely irritated and edematous. The disc herniation may impinge upon the right S1 nerve root centrally near its origin from the thecal sac.

On July 22, 2008, the claimant was re-evaluated by MD and MD. Prescription for Skelaxin and recommendation to continue therapy.

On August 15, 2008, EMG/NCV bilateral lower extremities interpreted by MD. Impression: There is current electrodiagnostic evidence that is consistent with bilateral L5-S1 radiculopathy. Right greater than left. Nerve conduction studies identified a markedly prolonged left tibial F-wave, and there was an absent left peroneal F-wave. Needle EMG revealed muscle denervation to the right extensor hallucis longus, and medial and lateral gastrocnemius. There is no evidence of peripheral neuropathy, myopathy, or entrapment syndromes.

On August 21, 2008, the claimant was re-evaluated by MD and MD. Prescription for Flexeril and Ultracet. Recommendation to continue therapy and diagnostic/therapeutic lumbar epidural steroid injection under fluoroscopy.

On September 4, 2008, L5-S1 epidural steroid injection performed by MD.

On September 1, 2008, the claimant was re-evaluated by MD and MD. It was reported the claimant had greater than 50% sustained pain relief with complete relief of left lower extremity pain. Second ESI recommended.

On September 17, 2008, L5-S1 epidural steroid injection performed by MD.

On October 10, 2008, the claimant was re-evaluated by MD and MD. It was reported she had excellent relief following the second ESI. Prescription for Skelaxin and Ultracet. Recommendation for diagnostic sacroiliac joint injection.

On October 21, 2008, the claimant was evaluated by DO, a designated doctor, who opined she had not obtained MMI. An FCE was ordered by Dr. and found the claimant to be at a LIGHT PDL level.

On November 13, 2008, Right sacroiliac joint intra-articular steroid injection performed by MD.

On November 17, 2008, the claimant was evaluated by MD. Physical Examination: Walked with antalgic gait favoring the right leg. Straight leg raising on the right at 40 degrees produced low back pain and leg pain. Motor exam revealed 5/5 strength in all lower extremity muscle groups. Sensory exam was intact to pinprick. Reflexes revealed a slightly diminished right ankle reflex. Reported constant lower back pain at 5/10. Diagnosis: Right lumbar radiculopathy, 2 mm right L5-S1 disc protrusion with disc desiccation in high intensity zone posteriorly. Recommendations: Lumbar myelogram. Prescriptions: Hydrocodone, Robaxin, and Relafen.

On December 23, 2008, Lumbar x-rays interpreted by MD. Conclusion: Mild L5-S1 disc narrowing. Lumbar Myelogram and Postmyelographic Lumbar Spine CT interpreted by MD. Conclusion: Small (2mm) bulges broadly posteriorly at L5-S1 and posterolaterally into the left L4-5 and L3-4 neural foramina, without demonstrated neural impingement.

On January 2, 2009, the claimant was re-evaluated by MD. Recommendations: Continuation of current medications and no surgical intervention at this time.

On January 27, 2009, Functional Capacity Evaluation found the claimant to be at a Light-Medium physical demand level.

On February 11, 2009, the claimant was re-evaluated by MD. Recommendations: Continuation of current medications and added Medrol Dosepak.

On March 17, 2009, the claimant was evaluated by MD, a designated doctor, who opined she had obtained MMI with a 10% whole person impairment.

On March 23, 2009, the claimant was re-evaluated by MD. Recommendations: Continuation of Relafen and Robaxin, discontinue Hydrocodone and begin Ultram 50 mg. Also begin a work hardening program.

March 24, 2009 – October 30, 2009, Work Hardening Progress notes from Clinic.

On March 27, 2009, the claimant was re-evaluated by MD and MD. Recommendation for a repeat sacroiliac joint injection.

On April 16, 2009, Right sacroiliac joint intra-articular steroid injection performed by MD.

On April 27, 2009, the claimant was re-evaluated by MD. Refill of Ultram, Relafen and Robaxin.

On July 30, 2009, Right L3, L4, and L5 median branch nerve blocks performed by MD.

On November 24, 2009, the claimant was re-evaluated by MD and MD. Diagnosis: Lumbar IDD, lumbar radiculitis, low back pain, SI joint dysfunction, and lumbar facet syndrome. Prescriptions: Vicodin. Recommendations: Epidural steroid injection.

On December 17, 2009, the claimant was re-evaluated by MD. A CT scan of the lumbar spine was ordered.

On January 12, 2010, the claimant was re-evaluated by MD. Awaiting approval for the CT scan. Dr. prescribed Medrol Dosepak, Flexeril, and Voltaren gel.

On January 15, 2010, the claimant was re-evaluated by MD. He noted she was not being allowed any further interventional treatment so was now seeing a surgeon. He refilled Hydrocodone and added Neurontin to her prescriptions.

On January 26, 2010, the claimant was re-evaluated by DC. He added to her diagnosis lumbar chronic pain disorder and order further evaluation by a psychologist.

On February 10, 2010, the claimant was evaluated by PA-C for MD. Diagnosis: Lumbar radiculitis, R/O radiculopathy. Plan: Prescription for Lortab and Flexeril, referral to spine surgeon.

On June 30, 2010, the claimant was re-evaluated by PA-C for MD. It was noted the were awaiting a BRC with TDI/DWC. She was being referred to Dr. and instructed to continue current medications.

On August 18, 2010, the claimant was evaluated by MD, neurological surgeon. Diagnosis: Chronic disk herniation L5/S1. Plan: A current high-resolution MRI of the lumbar spine to determine if she is a surgical candidate.

On September 14, 2010, MRI of the lumbar spine interpreted by, MD. Impression: 1. No central or foraminal stenosis is seen in the lumbar spine. 2. 2mm right paracentral protrusion at L5-S1 slightly displaces the right S1 nerve root posteriorly. Annular fissure is seen in the protrusion.

On September 23, 2010, note by MD stating the claimant is a candidate for a lumbar microdiscectomy.

On September 23, 2010, EMG/NCV of the bilateral lower extremities interpreted by, MD. Impression: EMG abnormalities suggest an S1 radiculopathy on the right. NCV is abnormal.

On December 1, 2010, Operative report by MD. Postoperative diagnosis: Herniated lumbar disk syndrome, L5-S1 on the right. Procedure: Lumbar microdiscectomy.

January 31, 2011 – May 19, 2011, Physical Activities Logs

March 1, 2011, the claimant was re-evaluated by MD three months postoperative. It was noted she has had a month of physical therapy and started to complain of a new onset of low back and right hip pain. Recommendation to continue therapy and added Lyrica to her prescriptions.

On March 16, 2011, the claimant had a behavioral medicine evaluation by MLA/LPC. Diagnostic Impression: Axis I: Pain disorder associated with work related injury medical condition and psychological factors. Adjustment reaction with physical symptoms. Axis II: Maladaptive and/or excessive defense mechanisms. Axis III: lumbar radiculitis. Axis IV: Psycho-social stressors related to injury: physical health, occupational/work, economical/financial. Psycho-social stressors related to injury: 3 moderate. Axis V: 55-60 Moderate symptoms, some difficulty with job-related functioning. Recommendation: Individual counseling.

On April 27, 2011, the claimant was re-evaluated by MD five months postoperative. He noted despite physical therapy and taking Lyrica the claimant was increasingly miserable with her leg pain. On physical examination she did have a positive straight leg raise on the affected right leg at 60 degrees and a diminished right ankle jerk and walked with a markedly antalgic gait. He recommended a high-resolution lumbar MRI with and without contrast.

On May 5, 2011, MRI of the lumbar spine without contrast interpreted by MD. Impression: 1. Postsurgical changes at L5-S1 level are consistent with recent lumbar surgery. There are no enhancing abnormalities identified. 2. Incidental

note is made of multiple fibroids within the partially visualized uterus. The largest measures 3.7 mm.

On May 5, 2011, the claimant was re-evaluated by MD. Recommendations: Continue Lyrica and therapy through Dr. office. She will only be seen in the future on an as needed basis.

May 19, 2011 – June 27, 2011, Counseling Notes by LPC.

On June 22, 2011, the claimant was re-evaluated by PA-C for MD. Recommendations were to continue current medication and individual counseling sessions. She was kept off work.

On July 20, 2011, the claimant was re-evaluated by PA-C for MD. Recommendation was an evaluation for chronic pain management.

On August 4, 2011, a note from PhD indicates the claimant's reported average pain remained at a 4 with a range of 4 to 7 on a scale of 1 to 10. Depression was mild (BDI-2=12) and anxiety was severe (BAI=27). Disability assessments indicated moderate disability presentation. Fear of physical activity and work activity were in the mild range (FABQ=5&18).

On August 11, 2011, Ultrasound of the lumbar spine interpreted by MD. Impression: Postop changes at L5-S1. Suboptimal study.

On August 18, 2011, Functional Capacity Evaluation by, OTR. Results of the test reveal the claimant was functioning at a sedentary work level. Based on the FCE results, it was recommended that the claimant would benefit from participating in a pain management program to work on general conditioning and strengthening as well as pain management techniques and coping skills.

On August 25, 2011, the claimant was re-evaluated by MD. It was noted that she was still having aggravation of the lumbar spine that is aggravated with activities. Dr. Skinner recommended she be evaluated for chronic pain management.

On August 31, 2011, MD performed a UR on this claimant. Rationale for Denial: The multidisciplinary chronic pain management program is neither supported by the Guidelines nor the specifics of this particular case. The claimant has had a number of psychiatric and psychological comorbidities which will prevent, impede, and delay a full recovery and likely diminish the benefit of the chronic pain management program. Moreover, the guidelines state that the chronic pain management program should not be a reprisal or repeat of prior treatment. The claimant has already had extensive physical therapy to date. She has had individual psychotherapy and group psychotherapy through her current pain psychologist. Finally, the amounts and quantities of physical therapy which the claimant has had to date have not been clearly documented or identified in advance. There is little recommendation on file as to why the chronic pain

management program and the amounts and quantities specified is needed here. For all these reasons, the request is therefore non-certified.

On September 8, 2011, a Request for Reconsideration letter from PhD.

On September 15, 2011, MD performed a UR on this claimant. Rationale for Denial: The reported date of injury was more than 3 years back. There is no documentation that the claimant has motivation to change and is willing to change her medication regimen. There are no clinical records submitted to validate that the claimant underwent an appropriate course of Physical Therapy or had a sufficient course of evidence-based exercise rehabilitative program and optimized pharmacological treatments. The pain evaluation of the claimant is also not well documented and submitted for review. Per the records provided, the claimant has high levels of psychosocial distress including depression, anxiety, pain and disability. She also had increased duration of pre-referral disability time; the date of injury was more than 3 years back. Per the records provided, the claimant smokes 2 packs of cigarettes per week and she has higher prevalence of opioids use. These are negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the program for this claimant. With this, it is deemed the clinical information submitted for this review does not establish the medical necessity of 10 sessions of chronic pain management program for the lumbar spine.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who suffered a lumbar stain on xx/xx/xxxx while lifting a 40-50 pound box. Her treatment to date has consisted of various medications, physical therapy, lumbar microdiscectomy at L5-S1 on December 1, 2010, consultation with a pain psychologist, and individual counseling.

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

Denial of Chronic Pain Management is upheld (agreed upon) per ODG Pain Chapter, criteria #6 and #9 aren't met. Submitted documentation does not present specifics for treatment, nor specifies expected outcomes. There is no documentation of functional goal return to work plans or medication weaning/management. All of particular importance given greater than 24 months of disability.

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)