

INDEPENDENT REVIEWERS OF TEXAS, INC.
4100 West Eldorado Pkwy' Suite 100 -373 . McKinney, Texas 75070
Office 469-218-1010 . Toll Free Fax 469-374-6852 e-mail:
independentreviewers@hotmail.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

09/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: unlisted physical medicine/rehabilitation service or procedure

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Chiropractic Examiner

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

MRI of the lumbar spine dated 02/20/12
Clinical report dated 03/21/12
Partial report dated 06/25/13
Independent medical evaluation dated 06/26/13
Clinical evaluation dated 07/01/13
Subsequent evaluation dated 07/23/13
Pain management follow up report dated 07/23/13
Initial assessment and evaluation dated 07/26/13
Functional capacity evaluation dated 08/01/13
Prior reviews, 1 undated and 08/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. Following this, he developed low back pain. The patient has had prior therapy and injections with no surgical intervention noted. Medications as of 06/26/13 included Hydrocodone, Etodolac, Gabapentin, and Tizanidine. Prior injections have included epidural steroid injections as well as a sacroiliac joint injection. The independent medical evaluation on this date showed a markedly obese male. There was paraspinal muscle spasms noted in the lumbar spine and gluteal regions. The patient ambulated with a right antalgic gait. There was inappropriate tenderness to light touch with inappropriate overreaction. Reflexes were trace to absent in the right patella and reduced in the left patella. The Achilles reflexes were 2+ and symmetric. There was generalized weakness in the right lower extremity secondary to pain. 1 cm of calf difference was noted; however, this was not felt to be consistent with atrophy. Due to the excessive pain behaviors on physical examination, further treatment was not recommended. recommended that the patient have further MRI studies as well as an orthopedic consult on 07/01/13. A subsequent evaluation on 07/23/13 indicated the patient did have prior physical therapy. The patient reported worsening in his low back. Physical examination showed weakness in the right lower extremity and there was loss of the normal lumbar curvature with associated tenderness and spasms. There was reported positive electrodiagnostic studies for radiculopathy. felt the patient would benefit from a chronic pain management program. The patient continued to be prescribed Norco as well as Tizanidine on 07/23/13. An initial assessment and evaluation for the patient for a chronic pain management program on 07/26/13 identified the patient as having elevated BDI and BAI scores in the moderate to severe range. The patient's FABQ scores for physical activity and work were at maximum and the patient's GAF score was 55. The patient was reported to have a physical demand level of sedentary. No validity testing was noted in the evaluation. There was a functional capacity evaluation performed on 08/01/13. The patient was felt to have a sedentary physical demand level. The testing showed valid and consistent effort.

The request for a chronic pain management program was denied by utilization review on an undetermined date. Per the report, there was no record of any surgical consults. There was also no documentation regarding a specific titration plan. There were also concerns regarding the patient previously participating in a work hardening program.

The request was again denied by utilization review on 08/22/13 as there was no specific documentation from the patient regarding motivation to change or willing to change his medication regimen. It also appears the patient had previously attended a work hardening program.

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

The clinical documentation submitted for review indicates the patient has had ongoing complaints of chronic low back pain radiating to the lower extremities. The clinical documentation submitted demonstrates objective findings for spasms in the

lumbar spine. The independent medical evaluation however identified several inconsistent pain behaviors on physical examination suggestive of symptom magnification. In this case, it was unclear whether the patient actually had attended a previous work hardening program as reported in the prior reviews. There was no documentation from a prior work hardening program. What is not present in the clinical record is a substantial and true multi-disciplinary evaluation for the recommended chronic pain management program. The initial assessment and evaluation on 07/26/13 did not contain any type of validity testing such as an MMPI2 or BHI2 assessment. This reviewer would opine that this validity testing is crucial in a patient with previously noted symptom magnification behaviors. Also, given that the patient reported maximum scores on fear avoidance behaviors, validity testing to support his self-subjective assessments would be needed in order to determine the appropriateness of a chronic pain management program. There is no documentation assessing that the patient would not benefit from further lower levels of treatment or that the patient is not a surgical candidate. It is also unclear to what extent the patient must improve in order to return to work. Given that the clinical documentation submitted for review does not meet guideline recommendations for the requested service, it is this reviewer's opinion that medical necessity is not established.

IRO REVIEWER REPORT TEMPLATE -WC

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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 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.