

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 4, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management for the lumbar spine- 80 hours (10 sessions)

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)

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:

02-06-12: Outpatient Testing Orders
02-08-12: MRI Lumbar Spine w/o contrast
06-06-12: Emergency Physician Record
06-12-12: Letter of Medical Necessity
06-18-12: Initial Evaluation
07-10-12: Letter of Medical
07-10-12: Texas Workers' Compensation Work Status Report
07-23-12: Functional Capacity Assessment
07-26-12: Review of Medical History & Physical Exam
07-31-12: Office Visit
07-31-12: Texas Workers' Compensation Work Status Report
08-02-12: Office Visit
08-17-12: Initial Office Consultation

08-17-12: CT Myelogram Lumbar Spine Imaging Request
08-21-12: Office Visit
09-18-12: Office Visit
09-18-12: Texas Workers' Compensation Work Status Report
09-20-12: Peer Review
09-26-12: Letter for continued care
10-02-12: Office Visit
10-02-12: Texas Workers' Compensation Work Status Report
10-04-12: Initial Medical Report at Pain & Recovery
10-04-12: Texas Workers' Compensation Work Status Report
10-16-12: Behavioral Evaluation Report
10-16-12: Work Capacity Evaluation
10-22-12: Pre-Authorization Request
10-26-12: UR
10-30-12: Request for Reconsideration
11-05-12: Subsequent Medical Report
11-05-12: Texas Workers' Compensation Work Status Report
11-12-12: UR
12-19-12: Response Letter to UR

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that was injured while at work. As he got out of a truck, he fell to the ground as his knee buckled and he landed on his buttocks and began to have back pain after that.

02-08-12: MRI Lumbar Spine w/o contrast. Impression: Negative MRI of the lumbar spine.

06-06-12: Emergency Physician Record. Claimant presented complaints of back pain with numbness and tingling to the right leg and with left leg shaking uncontrollably. Pain rated at 7/10. PE: Noted coarse tremors to entire left leg. Follow up with Spine Clinic. Diagnosis: Back Pain.

06-12-12: Letter of Medical Necessity. stated that after the claimants designated doctor examination, he was claimant does have a positive Faber's confirmed by posterior shear testing and he complains of uncontrollable left side shaking and referred him to neurology.

06-18-12: Initial Evaluation. Chief complaint: Low back pain with right leg pain. Medications: Tramadol 50mg, Norco 10/325, Tizanidine 4mg. PE: Lumbar Physical Exam: Trigger Points: right, paraspinal, pisiforms. ROM: limited with extension, flexion and right axial loading all causing pain. Facet tenderness at L3-4, L4-5, L5-S1 all on the right. Straight leg raise positive on the right at 65 degrees. SI Joint tenderness positive on the right. Motor: Right 4-5/5 @ L4, L5, S1. Diagnosis: 724.6 Disorders of sacrum; 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified. Assessment Plan: 1. After clinical examination of the claimant, he presents with significant right sided sacroiliac joint pain. His

MRI is essentially normal while his physical exam is consistent with symptoms of radiculopathy in particular a positive straight leg raise test on the right and decreased motor strength on the right. Claimant would benefit from a right sided sacroiliac joint injection to be done under monitored anesthesia utilizing fluoroscopic guidance. 2. Recommend the claimant be referred to psychologist due to his admission of severe depression and may need antidepressants in the future. 3. Prescribed Lorcet 10/850 po tid for pain; Tramadol 50mg po tid to qid for pain; Tizanidine 4mg 1-2 po QHS prn spasms. Discontinued Norco due to ineffectiveness. 4. TEMS unit. 5. Follow up with two months.

07-23-12: Functional Capacity Assessment. Areas of Complaints: Lumbar Spine. Occupational Demands: Heavy PDL. The claimant is currently performing at a Light-Medium PDL, which indicates moderate functional deficits.

07-26-12: Review of Medical History & Physical Exam. Physical Examination: Musculoskeletal Exam: Patrick Faber's was positive on the right ; pelvic rock was noted to be uncomfortable on the right; Yeoman's was also noted to be uncomfortable on the right; however not as much splinting or guarding as detected previously. Trigger points noted in the right paralumbar musculature. PSIS on the right was tender. Diagnosis: Lumbar strain and right SI joint pain/strain.

07-31-12: Office Visit. Claimant received injection with minimal relief. Diagnosis: 724.2 Lumbago 719.46; Pain in joint of lower leg 722.0; Cervical Disc Displacement without myelopathy. Impression and Plan: Progress to active based therapy. Claimant reports no significant improvement post injection. Follow up in 3 weeks.

08-02-12: Office Visit. Chief complaint: claimant complains of low back pain, radiating pain aggravated by bending, extending, lifting and when lying down, sitting, sleeping, standing, and walking. He stated that nothing relieves his pain and is scheduled for surgical appointment on 8/17/12. Diagnosis: 724.2 Lumbago 719.46; Pain in joint of lower leg 722.0; Cervical Disc Displacement without myelopathy. Daily Patient Therapy Note: Claimant was treated with electrical stimulation ultrasound and hot/cold pack; 30 minutes. Treatment performed in the lumbar region. Plan: No complications with treatment.

08-17-12: Initial Office Consultation. Chief complaint: low back pain, right leg pain and numbness, left foot intermittent numbness. Assessment diagnosis: 724.2 Lumbago, 724.4 Radiculopathy. Claimant has long standing h/o lumbago with lumbar radiculopathy and has a positive SLR in his right LE. Due to a negative MRI would recommend a CT myelogram of his lumbar spine prior to making future treatment plans. Treatment Plan: CT myelogram lumbar spine.

10-04-12: Initial Medical Report. Objective Clinical Examination: Lumbar spine revealed tenderness of the lumbar paraspinals on the right side and right SI joint. Lumbar ROM was restricted with increase in pain. Straight leg test is positive and

also noted decreased sensation of the right lower extremity. Initial Diagnosis: Lumbar radiculitis; Disc bulge of the lumbar spine; Lumbar sprain/strain. Treatment Plan: Refer for MHE and FCE; Recommend claimant see his PCP regarding HBP; Medications: continue Norco and Fentanyl patch that he has at home; Work status: work with restrictions (the employer cannot accommodate light duty); follow up in four weeks.

10-16-12: Behavioral Evaluation Report. Diagnostic Impression: 29622 Major Depression – Moderate (Injury Related); 307.89 – Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. Severity of Psychosocial Stressor 3 Moderate levels of pain, frustration, and disruption of many activities due to injury. Increased financial difficulties. Global Assessment of Functioning: Current: 65-Moderate symptoms; Best on the Last year: 75-Moderate symptoms. There is a casual relationship between the current pain, related mental health, psychosocial and functioning deficit symptoms and the compensable injury sustained on 11/18/10. Treatment Plan: Mental Health Evaluation for symptoms of depression and anxiety by a medical consult. Treatment Modalities: Claimant's individualized outpatient Chronic Pain Management Program daily plans include interventions to achieve primary goals to include increase appropriate use of medication, decrease intensity of subjective pain, increase ability to manage pain, reduce health care use related to chronic pain syndrome, increase capabilities for return to work, improve functional capabilities by changes objectively documented, increase his psychological and psychosocial coping capabilities to manage individual rehabilitation needs for medically reasonable recovery in occupational and social daily living activities and achieve significant medical care case closure for this compensable injury. Treatment Recommendations: Claimant is a candidate for multidisciplinary program, which consists of 20 sessions, however, it is recommended that participate in 10 sessions of chronic pain program to insure him the medical benefits that he is entitled and as a con-current evaluation to assess his compliance and therapeutic response to treatment.

10-16-12: Work Capacity Evaluation. Occupational Demands: Heavy PDL. 7/23/12 Claimant performed at a Light-Medium PDL. He is currently not working. According to the results of the evaluation the claimant is currently performing at a Sedentary-Light PDL, which indicates a moderate functional deficit.

10-26-12: UR. Reason for denial: The request is not certified. It was noted the claimant had a diagnosis of lumbar strain with a small disc bulge at L5-S1. The MRI was not available for review. W FCE on 7/23/12 documented claimant was functioning at a light/medium PDL. A physical examination was not available for review. The claimant has high psychosocial stressors with a high BDI score of 26. The claimant was functioning at a sedentary/light PDL and had disgressed. There are no sensory, motor or neurologic deficits. The claimant has high level medication use including Fentanyl, Norco, and Elavil. The request for chronic pain management for the lumbar spine 80 hours (ten sessions) is not certified.

11-12-12: UR. Reason for denial: Clinical data submitted indicates the worker has been diagnosed with lumbar strain injury and exacerbation of an underlying/pre-existing lumbar disorder per the chiropractic physician treating the worker earlier in the course. There is mention of a small L5-S1 bulging disc but there is no evidence this represents a clinically significant annular tear or the presence of a focal neurocompressive lesion. The worker has been exposed to injection therapy that has included SI joint injection and/or epidural steroid injection (or both), though this is not clear in the chiropractic physician's records. There is no indication the claimant has been judged to have a spinal condition that warrants surgical intervention. The claimant has been provided prescriptions for medications that are clearly not provided adequate therapeutic benefit but represent increased dosing with opiates. The claimant is reported to be applying a Fentanyl 25mcg patch every two days (usually every three day application), plus consuming at least three Norco 7.5/325mg tablets per day, along with Ambien for sleep. The claimant is reported to exhibit a positive straight leg raise maneuver on the right to have sensory and motor deficits, but there is electrophysiology verification of clinically significant active nerve root irritation. The prior reviewer cites the absence of physical examination and the MRI report as reasons for non certification, noting that no sensory, motor or neurological deficit could be verified. The reviewer did note the "high level medication use", but offered no suggestion to weaning or alternative approaches. There is documentation of the claimant having and undergone electrodiagnostic study but there is no indication this study was positive for active nerve root irritation. The diagnosis under which the reviewer was performed was recorded to be lumbar strain. The work capacity evaluation notes the claimant's employment citing the heavy physical demand level category of work requirement, while noting the claimant performed at the light/medium physical demand during the assessment, which may suggest the need for further therapeutic exercise and possibly some job simulation training, but does not of its self warrant participation in a chronic pain management program. The mental health evaluation highlights issues of psychosocial stresses and potential barriers to recovery due to symptoms of depression (BDI – 26) and anxiety (BAI – 16), both of which are in the moderate range. PAIRS and BPI are elevated providing further documentation of psychosocial factors and pain perception issues that may impact functional recovery. There is no documentation of the claimant having participated in any form of mental health services prior to the evaluation and the summary of physical rehabilitation services suggest there may have been an emphasis on the use of passive physical modalities versus participation in a program of progressive function-oriented active rehabilitation efforts. In the absence of documentation of clinically significant neurologic impairment as has been inferred and the documentation of prior enrollment of some form of mental health services, the medical necessity for progression to a formal comprehensive tertiary care service cannot be established at this time.

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

Denial of 80 hours of Chronic Pain Management is upheld/agreed upon. Per ODG Pain Chapter, submitted information does not include a recent thorough history and physical exam and the FCE on 7/23/12 is several months old. Also, submitted documentation does not clarify whether lower levels of care have been exhausted. There is lack of information regarding the number and type of rehabilitation visits and lack of information regarding previous injections and surgical candidacy. Therefore, the request for Chronic pain management for the lumbar spine- 80 hours (10 sessions) is not medically necessary and therefore not certified.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p>
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(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

	<p>participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> 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.</p>
<p>Chronic pain programs, early intervention</p>	<p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <p>(a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity.</p> <p>(b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis.</p> <p>(c) Risk factors are identified with available screening tools or there is a previous medical history of delayed recovery.</p> <p>(d) The patient is not a candidate where surgery or other treatments would clearly be warranted.</p> <p>(e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions.</p> <p>(f) Evidence of psychosocial barriers that make return to work unlikely.</p> <p>(g) Loss of employment or evidence of partial disability involving ability to perform only "part-time" work or work with "light-duty" restrictions for greater than 4 months. (Mayer, 2003) (Gatchel, 2003) For general information see Chronic pain programs.</p>

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)**