

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

February 24, 2014

### **IRO CASE #:**

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

80 Additional Hours of Chronic Pain Management (10 sessions)

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

The Reviewer is Board Certified in the area of Physical Medicine & Rehabilitation with over 16 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:**

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained an injury on xx/xx/xx. The claimant felt a sharp pain to the low back which radiated immediately down the right leg. He underwent physical therapy and three ESI injections to the lumbar, however the pain persisted. He underwent back surgery on September 2011; however the pain continued to persist.

05/25/2010: MRI of the Lumbar Spine. Impression: 1. Bilateral posterolateral 2-3 mm protrusions at L4-5 with moderate facet arthropathy creates mild/moderate stenosis with bilateral lateral recess and foraminal encroachment. 2. Richat

paracentral 3-mm protrusion at L5-S1 with facet arthropathy creates effacement of the thecal sac with some mild right-sided foraminal encroachment. 3. Right paracentral 2-mm protrusion at L3-4 with facet arthropathy creates effacement of the thecal sac with some right lateral recess and inferior foraminal encroachment.

05/14/2011: MRI of the Lumbar Spine. Impression: A) At L5-S1, There is posterior protrusion subligamentous disc herniation in the central and right lateral aspect measuring 3-3, 6 mm in ap diameter, touching the thecal sac. There is a tear in the posterior annulus fibrosus in the central and right lateral aspect. Hypertrophic changes are seen in the facet joints. There is slight right inferior neural foraminal stenosis at this level. B) Posterior bulging disc at L2-L3, L3-L4 and L4-L5. There is a tear in the posterior annulus fibrosus centrally at the L2-L3 level.

06/10/2011: Nerve Conduction Study/EMG. Impression: 1. Multilevel lumbar radiculopathy involving the L4, L5, and S1 nerve roots bilaterally, which appears to be most significant at the right L4, L5, and S1 nerve root levels. Lumbar radiculopathy was indicated by increased reinnervation potential activity recorded in L4, L5 and S1 innervated paraspinals and distal musculature within the lower extremities bilaterally. Reduced motor unit recruitment patterns were also observed within the right L5 myotome. Right L4 radiculopathy was further suggested by reduced femoral motor amplitude values recorded at the right Vastus medialis relative to the contralateral study. Right L5 radiculopathy was further suggested by reduced peroneal motor amplitude values recorded at the right EDB, prolonged peroneal f-wave latency values recorded at the right EDB, and prolonged cortical latency values recorded in right L5 DSEP studies. Right S1 radiculopathy was further suggested by prolonged tibial f-wave latency values recorded at the right abductor hallucis and prolonged tibial h-reflex latency values recorded at the right soleus. 2. No electrophysiological evidence of distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities.

09/06/2011: Operative Report. Postoperative Diagnoses: 1. Spinal stenosis, L3. 2. Spinal stenosis, L4. 3. Spinal stenosis, L5. 4. Spinal stenosis, S1. 5. Bilateral lumbar radiculopathy. 6. Neurogenic claudication. Operations Performed: 1. Decompressive laminotomy, L3. 2. Decompressive laminotomy, L4. 3. Decompressive laminotomy, L5. 4. Decompressive laminotomy, S1. 5. Bilateral foraminotomies, L3-4, L4-5, and L5-S1.

01/23/2012: Follow-up Mental Health Evaluation. The claimant completed 6 individual counseling on 1/13/2012, which he stated helped significantly to better cope with his injury. He continued to complain of chronic pain to the low back post surgery with a pain level of 4/10. He is sleeping better 6 hours nightly with a significant decrease in anxiety. He admitted to continued depressed mood over issues of having to cope with constant pain and inability to perform simple tasks such as bending or lifting. He is more focused on returning to work. He is less irritable and angry. Claimant underwent physical therapy and three ESI injections, to the lumbar, however, the pain has persisted. He underwent back surgery

09/2011; however, the low back has been persisted. Claimant can no longer do heavy lifting. Medications: None. The patient is being recommended for 10 chronic pain management sessions to address his chronic pain and associated symptoms of depression/anxious mood and help increase coping skills.

02/20/2012: Appeal letter. indicated the claimant was on Ultracet 1 tab q8, prn, and Mobic 7.5mg 1 tab.

03/02/2012: Physical Examination. Subjective: Patient estimated his low back pain at 3/10. Medications include Ultracet one po q 8 h prn and Mobic 7.5 mg one po bid. Physical Examination: Kemp's test was positive bilateral, Sicard's sign is absent on the right, Patella Reflex is /5 on the right and Achilles Reflex is /5 on the right. Plan: Claimant has been evaluated for Chronic Pain Management and found to be an ideal candidate. Diagnosis: Displacement of Lumbar Intervertebral Disc without Myelopathy.

03/06/2012: IRO for 80 hours of chronic pain management. Analysis and Explanation of the Decision: Based on the clinical information provided, the request for 80 hours of chronic pain management is not recommended as medically necessary and the two previous denials are upheld. The submitted records fail to reestablish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient underwent decompression laminectomy L3-S1 and bilateral foraminotomies L3-L4, L4-L5 and L5-S1 on 09/06/2011. However, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary.

02/05/2013: Lumbar Spine MRI with and without Contrast. Impression: 1. Since the previous exam, L3-L4, L4-5 and L5-S1, laminectomy changes are now seen. The canal narrowing at L3-4, L4-5, and L5-S1 are not significantly changed from the previous exam. The mild to moderate natural foraminal anarachment from L3-4 through L5-S1 is not significantly changed from the previous study. 2. The spinal canal at L2-3 is mildly narrowed due to spondylasts and annular disc bulging, unchanged from the previous exam. 3. I see no canal or foraminal stenosis at L1-2. 4. Subtle annular tears at the L2-3, L3-4 and L4-5 levels show no associated focal disc herniation.

02/25/2013: Letter. Claimant was seen in the office on 2/25/2013 for continued back pain. The claimant had an updated MRI scan on 2/5/2013. There were obviously postoperative changes. There was adequate room for the thecal sac at L2-3, L3-4, L4-5 and L5-S1. There was no nerve root compression at those levels. Examination showed some decrease in range of motion with flexion of 40 degrees. He had tenderness in the paraspinal muscles, and he had pain with range of motion. It was suggested he may be a candidate for a lumbar epidural steroid injection.

08/22/2013: Evaluation. Current Status: Medications continue to be helpful. He is sleeping at night, but when the pain is severe he does not sleep. He walks with a cane. Physical therapy used to help. Medication: Tramadol 50 mg, Zanaflex 4 mg, Ambien 5g and Gel 3. Recommendations: 1. Orthopedic surgeon consult to assess need for ESI. 2. Physical therapy twice a week for 8 weeks.

08/23/2013: Physical Examination. Subjective: The claimant present with moderately severe low back pain. He described it as constant moderately severe restricted movement and tingling sensations as well as achy and dull pain radiating to the right gluteal area, right upper-lateral thigh, right lower-lateral thigh and right calf. He stated that sitting, bending and arising from a chair appears to increase his degree of low back pain. He estimated his low back pain at 6/10. Physical examination: Femoral Nerve Stretch Test is positive bilateral, Double leg Raise sign is present bilateral and Straight leg Raise test is positive bilateral. Evaluation of the dermatomes utilizing a pin wheel revealed all dermatomes tested were normal except right L5 hypoesthesia and right S1 hypoesthesia. The spine and paraspinal tissues were examined and show a moderate degree of pain at L1-L5 bilaterally. There is evidence of a swelling of a moderate severity at L1-L5 bilaterally noted on palpation. Palpation revealed moderate tension of the lumbar paraspinal muscles bilaterally. Plan: Referring the claimant for an orthopedic evaluation for ESI. Normal work duties are unable to be performed by the claimant. The claimant is totally disabled and removed from work.

11/22/2013: Request for 80 hours for Chronic Pain Management Program. It was indicated that the claimant underwent a Functional Capacity Evaluation and the test identified functional capacity of light physical level.

11/22/2013: Evaluation. Claimant presented to the office with complaints of low back pain, tenderness and swelling of the para-spinal muscles in the lumbar area. Limitation of range of motion in the lumbar area. A mental health evaluation and FCE were recommended.

11/25/2013: Mental Health Evaluation. Background: Complaint of chronic pain to the low back post surgery with a pain level of 6/10. He sleeps about 2-3 hours nightly due to discomfort which exacerbates his anxiety. He admits to depressed mood over issues of having to cope with constant pain and inability to perform simple tasks such as bending or lifting. He has poor concentration and is irritable and is easily angered. He feels a loss of independence since he cannot do the normal daily tasks he used to before the injury, especially heavy lifting. He has low energy, and a loss of interest in most activities, but is motivated to change and return to work. He admits to being virtually isolated. Present Medications: Tramadol 50mg, Zanaflex 4mg, Ambien 5mg. Vocational: He returned to work for the company for five months, but could not tolerate the pain. He has not worked since his surgery. He will be referred for re-training. He has not had any prior work restrictions. He feels that he has lost functionality. ADLs: He can do limited home chores. He cannot do house cleaning. He can drive for himself, but not for prolonged periods. Assessment Procedures: BDI-II is 35/63, severe level of depression. BAI is 33/63, severe level of anxiety. Diagnosis: Axis I: Pain

disorder associated with both a psychological and a general medical condition. Axis II: Deferred. Axis III: S/P low back surgery. Axis IV: Moderate. Axis V: 55. Prognosis: Good. Recommendations: It is strongly recommended that this patient be admitted to an interdisciplinary Chronic Pain Management program, pending insurance approval: for 2 weeks, 5 days a week, 8 hours a day. The patient's life has clearly been disrupted in many respects as a result of his injury and Pain Syndrome. The issues of a self-management approach should be addressed in a program to include: A. Behavioral Treatment. B. Program to include Physical Therapy/Medicine to enhance patient's physical capacity and avoid continued deconditions. C. Cognitive/Behavioral individual psychotherapy in context with the Chronic Pain Management program and also to address his increased anxiety and depressed mood.

12/11/2013: Functional Capacity Evaluation. Conclusions and Recommendations: Based on the data obtained throughout this evaluation, Mr. is currently in a medium work classification as determined by NOISH standards. It is medical opinion of the evaluator that Mr. is currently unable to perform work duties without the risk of re-injury to one-self. Test data also indicated that the patient has significant deficits in muscle strength, range of motions, physical demand, and especially in regards to their static positional posture tolerance. Patient shows signs of depression according to Goldberg exam. Recommendation to follow-up with orthopedic management healthcare provider is indicated at this time. Test data indicates that Mr. has significantly deficits in muscle strength, range of motion, physical activities endurance, and static positional tolerance. The patient is recommendation to begin a more helpful functional such as chronic pain would be effective in addressing depression, deficits and addressing their ROM issues as well, to get them back to work in a time efficient manner.

12/18/2013: UR regarding initial 80 hours of pain management. Rational for Approval: The history and documentation support the request for a chronic pain management program at this time. The claimant has chronic pain with severe depression but is reasonably functional and capable of medium work. This request is reasonable and appropriate and 80 hours can be recommended as an initial course of treatment.

01/09/2014: 30 Day Follow-Up to Initial Mental Health Evaluation. Background Information: He completed 10 Chronic pain management sessions which he states helped him significantly to better manage his chronic back pain. He still describes a pain level of 5/10 with muscle strengthening and an improved ROM. He sleeps about 6 hours nightly and resting better with a significant decrease in his anxiety. He says he is coming out of his depression and is more focused on returning to work. His concentration has improved and he is less irritable. Assessment procedures; BDI-II is 22/63, moderate level of depression. BAI is 19/63, mild level of anxiety. Diagnosis: Axis I: Pain disorder associated with both a psychological and a general medical condition. Axis II: Deferred. Axis III: S/P low back surgery. Axis IV: Moderate. Axis V: 57. Recommendations: It is strongly recommended that this patient continue in an interdisciplinary Chronic Pain Management program, pending insurance approval; for 2 weeks, 5 days a

week, 8 hours a day. The patient's life has clearly been disrupted in many respects as a result of his injury and Pain Syndrome. The issues of a self-management approach should be addressed in a program to include: A. Behavioral Treatment. B. program to include Physical Therapy/Medicine to enhance patient's physical capacity and avoid continued deconditions. C. Cognitive/Behavioral individual psychotherapy in context with the Chronic Pain Management program and also to address his increased anxiety and depressed mood.

01/21/2014: UR. Rational for Denial: The request for participation in ten (additional) sessions of the chronic pain management program is based upon the initial certification for trial enrollment dated 12/18/13. Since that time the worker has participated in the ten sessions and is reporting improvement in restorative sleep duration (now at six hours) and a one-point reduction in perceived pain levels. There is no documentation of a reduction in the medication consumption documented. Beck screening inventories document a 40-50 percent reduction while the GAF remains essentially unchanged. There is no objective clinical data presented that identifies clinically significant changes in functional activity tolerance. The goals of the program are presented in terms of the enhancement of pain management cognitive behavioral strategies and reinforcement of the positive gains rather than in objectively determined and measurable parameters. There is no evidence of any coordination of vocational preparedness beyond the intent to refer to worker for retraining. Per clinical guidelines: 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, the nature of the activities ( and the lack of activities cited that are of a more functional orientation) raise concern that the continuation of the current program will leave the worker out of eligibility but with a significant function deficit. The medical necessity for the continuation of the program cannot be determined in the absence of documentation of the function components of the chronic pain management program and the worker's current status, progress and objectively identified goals.

01/28/2014: Appeal Letter. responded to the denial by stating the claimant's vocational status remains essentially unchanged. That the claimant receives and documented in his chronic group therapy sessions instructions on setting work goals, checking on training programs on at least three vocational schools, obtaining literature on training programs, how to narrow down work goals. also made the argument that the patient has not concluded the Chronic pain program and is not asking for re-enrollment in any other program. He is asking to complete the Chronic Pain program which he has already started and made positive gains.

02/08/2014: UR. Rational for Denial: Based on the clinical information provided, the request for 80 additional hours of chronic pain management (10 sessions) is not recommended as medically necessary. The patient has completed 80 hours of a work hardening program as well as 80 hours of chronic pain management program without sustained gains in physical functioning. Additionally, there is no indication that the patient has undergone psychotropic medication assessment or referral.

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

Uphold/agree with the denial of an additional 80 hours of chronic pain management program. Despite improvements in psychometric parameters, there has been very little change in GAF, which denotes disability. There is no documentation of physical/functional gains. There is no documentation of reduction of habituating medications. Therefore, the request for 80 Additional Hours of Chronic Pain Management (10 sessions) is denied.

PER 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)**