



**MEDICAL EVALUATORS
OF TEXAS ASO,LLC.**

2211 West 34th St. • Houston, TX 77018
800-845-8982 FAX: 713-583-5943

DATE OF REVIEW: November 3, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program-80 hours/unit-Outpatient

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

This case was reviewed by a chiropractor who is currently licensed and practicing in the state of Texas.

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)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained injury on xx/xx/xx when he was lifting a heavy box at work and felt a pop in his lower back. The claimant was diagnosed with lumbar herniation at L5-S1 with S1 radiculopathy. The claimant has been previously treated without any relief with 16 sessions of physical therapy, 160 hours of work hardening, and medications including Cymbalta, Escitalopram, Gabapentin, Tramadol HCL, Hydroxyzine HCL.

The claimant had MRI of the lumbar spine on 04/04/2013 that showed large right paracentral disc herniation at L5-S1 with nerve root encroachment resulting in severe spinal stenosis. Physical performance evaluation dated 02/11/2015 showed the evaluatee's required PDL is Heavy and was tested in the Medium lifting category. On 05/05/2014, the claimant underwent right decompressive laminectomy with medial facetectomy and excision of subligamentous disk herniation decompressing the S1 nerve root.

A progress note dated 08/08/2015 indicates the claimant has chronic low back pain for over 2-1/2 years. The claimant is receiving pain medication and is requesting more pain medication. The claimant states that he was doing well with his therapy and work hardening program but has stopped doing his stretches and now is having more pain. On exam, there was mild muscular tenderness, range of motion was pretty good with flexion of 60°, extension 10°, straight leg raise negative bilaterally, his knee jerks symmetrical



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and absent, ankle jerks absent, and sensation reduced in both legs and feet presumably from diabetic neuropathy.

The claimant has been evaluated for a comprehensive psychological testing and assessment on 08/27/2015 and according to the psychological evaluation the claimant was diagnosed with moderate, persistent somatic symptom disorder, with predominant pain; major depressive disorder, single episode, without psychotic features; and anxiety disorder. The claimant was recommended interdisciplinary chronic pain program in order to reduce his pain and fear avoidance behaviors while improving his physical capabilities and functioning in order to propel this patient towards safe return to work and facilitate medical case closure.

Prior UR dated 09/09/2015 denied the request for coverage for Chronic Pain Management Program-80 hours/unit-Outpatient based on: First, the claimant is more than XX from his injury. This reduces the chances of any positive benefits that may result from a chronic pain management program, as elucidated in the guidelines too. Second, the claimant has had considerable medical and surgical treatment as well as physical medicine treatment. This includes 160 hours of work hardening, 16 sessions of PT, medications, injections and surgery, and yet he has had virtually no improvement in his condition in terms of reported function or pain. Third, the claimant's psychological assessment indicates on the MMPI, an above average infrequency response rate. As acknowledged by the psychologist doing the assessment, the patient has numerous nonspecific somatic and neurological complaints. The BHI-2 inventory demonstrated a low level of psychological defensiveness, which, although not diagnostic of magnification of symptoms or the desire to express to others his distress, is entirely consistent with these phenomena. Fourth, the claimant has had psychopharmacological therapy with potent SSRI and NSRI treatment, even in combination, along with neuroactive agent therapy including gabapentin. Despite this, his psychological condition has not improved at all, and neither has his pain. Indeed, according to the records, everything has gotten worse. Fifth, the psychologist, despite noting a "severe" level of depression and considerable anxiety, did not inquire about suicidality or prior suicide attempts or suicidal ideation and planning. This raises the question of whether the psychologist's clinical impression was different and less grim than the Beck depression inventory would suggest in summary, the weight of the evidence strongly argues that this individual is unlikely to respond to a chronic pain management program with any benefit. The data submitted by the requesting physician and the pain management team pertains to individuals who are less than XX out from their injury and do not demonstrate serious red flags on psychological testing. As such, they do not apply to the individual in question. Therefore, he is in fact NOT a good candidate for chronic pain management.

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

After review of the submitted medical records, this claimant's injury is XX years old and ODG recommends there is conflicting evidence that chronic pain program is beneficial in



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providing return-to-work beyond this period. The records do not demonstrate that there is discussion of the claimant's motivation to change or discussion of several negative predictors of success including psychiatric pathology and financial problems. There is documentation of lumbar tenderness but otherwise physical exam shows no abnormal findings indicating significant loss of ability to function independently or decreased ability to perform ADL's. There is no reasonable medical probability that this claimant will benefit from further care. It is reasonable that there is no further improvement expected with continued care.

Based on the ODG as well as clinical documentation stated above, the request is not medically necessary and appropriate. The request is non-certified.

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)



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**ODG- Official Disability Guidelines & Treatment Guidelines - Online version
Chapter - Pain (Chronic)**

Chronic pain programs (functional restoration programs)

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.



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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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (Sanders, 2005) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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).



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(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.

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NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.