

# Health Decisions, Inc.

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11/16/15

## IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Additional Chronic Pain Management x 10 sessions, 5x 2 weeks, for neck, lumbar, R shoulder, right knee.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** American Board Certified Physician in Physical Med. and Rehab with over 20 years' 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.

## PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a female who sustained an injury on xx/xx/xx. The patient was walking through the work area with floor wet with soup. There was no wet sign and the patient slipped and landed on the right side. According to other UR reports reviewed, Prior treatments included physical therapy, medications, 10 sessions of chronic pain management, work conditioning and psychological therapy. The patient's medications were Tylenol and Codeine No. 3, Naproxen and Flexeril. There was noted improvement with ROM and strength. The pain was alleviated by medications. The patient underwent anterior cervical discectomy and fusion of C5-C6 and C6-C7 on, lumbar spine surgery, and arthroscopy of the wrist. The MRI of the right shoulder documented that there was suprapinatus tendinopathy without a tear. There was no bone contusion or fracture. According to the Office visit, the patient complained of moderate pain that was rated 5/10 on the lumbar spine with pressure and travelling pain in to the lower extremity. There was moderate pain that was rated 4/10 on the right shoulder with burning and tingling sensation that travelled into the trapezius and right upper extremity. The pain was much worse by prolonged walking, prolonged standing, physical activity, lifting, carrying and active and passive motion. The pain was precipitated by extension and flexion. On exam of the cervical spine, the ROM on flexion was restricted and approximately 48 degrees, extension was restricted and approximately 45 degrees, and bilateral lateral bending was restricted and approximately 40 degrees. There was an old scar on the anterior aspect of the neck. On exam of the lumbar spine, there was tenderness at the middle portion. The ROM on flexion was restricted and approximately 42 degrees, extension was restricted and approximately 18 degrees, left lateral flexion was restricted and approximately 21 degrees, and right side bending was restricted and approximately 17 degrees. Treatment plans included 1) prescription of biofreeze to relieve pain in sore muscles and joint, sprain and strain, and backache. 2) 10 additional session of chronic pain management to continue with improvement and allowed the patient a better quality of life, 3) and follow up in 1 month. This patient was diagnosed with cervical brachial radiculitis, lumbar

sprain, unspecified sprain of the shoulder and arm, and unspecified sprain of the knee and leg.

: Visit summary: Assessment: the patient participated well. The client was cooperative and was oriented x 3. The client reported her pain level to vary between 5 and 7. She was diagnosed with chronic pain disorder associated with both psychological factors and a general medical condition. Furthermore she exhibits symptoms of depression and anxiety, but makes a conscious effort to maintain a positive attitude. Plan: the patient will continue with attending medical appointments to assess her progress and address any medical options. The goal of her course of care continues to improve the client's self-awareness, and improve her ability to manage her pain levels. Will practice learned techniques at home. It is recommended that the patient attend an additional 10 sessions of Chronic Pain Management being that there appears to be limited options of treatment. All options appear to lead to serious adjustments in her life activates. Pt participated in physical therapy and showed a positive attitude toward others. It was noted that ROM on her right shoulder is increasing gradually but the pt is still having difficulty extending/flexing and abducting/adducting her right shoulder. This was especially true when attempting to do it in shallow water with floating resistance. Because she has been building strength slowly, we continued performing the exercises with floating devices held in hands to provided resistance in the water. She complains of a strong burning sensation that increases when there is effort applied to her shoulder. The patient still has difficulty flexing/extending her right knee. Biking exercises were done with more resistance than last session. The patient had to take constant rest periods in between the exercises to prevent pain levels from rising to high. It was noted that the patient could withstand periods of prolonged sitting without complaint. The patient is also able to walk at a normal pace and stand up for extended periods of time inside the shallow pool. The patient is beginning to build up speed with using stairs. Brake periods have begun to decrease in number when compared to the first session. Today is the patients last session. Awaiting doctor's evaluation.

: Visit Summary: This patients chief complaint is a work related injury. Pt comes for one month follow up. The patient reports cervical spine moderate (5/10) pain with pressure and swelling. Lumbar spine moderate (5/10) pain with pressure and traveling pain into the right LE, Right shoulder moderate (4/10) pain with burning and tingling sensation traveling into the trap and right UE. Pain is alleviated by medications. Pt reports no side effects with current medications. Continue with current medications. Pending report xxxxon. Patient completed 10 sessions of CPM and noted improvement with ROM and strength. I recommend/ requesting 10 additional session of CMP to continue with improvement and allowing the patient a better quality of life. Follow up in one month. The pain was precipitated by extension and flexion. On exam if the cervical spine, the ROM on flexion was restricted and approximately 48 degrees, extension was restricted and approximately 45 degrees, and bilateral lateral bending was restricted and approximately 40 degrees. There was an old scar on the anterior aspect of the neck. On exam of the lumbar spine, there was tenderness at the middle portion. The ROM on flexion was restricted and approximately 42 degrees, extension was restricted and approximately 18 degrees, left lateral flexion was restricted and approximately 21 degrees, and right side bending was restricted and approximately 17 degrees. Treatment plans included 1) prescription of biofreeze to relieve pain in sore muscles and joint, sprain and strain, and backache. 2) 10 additional session of chronic pain management to continue with improvement and allowed the patient a better quality of life, 3) and follow up in 1 month. This patient was diagnosed with cervical brachial radiculitis, lumbar sprain, unspecified sprain of the shoulder and arm, and unspecified sprain of the knee and leg. Work Status: Out of work due to patients presenting symptomatology and objective findings elicited upon evaluation, this patient will be unable to participate in any work activities. Patient currently status is pending CMP program and CT scan for the lumbar and cervical.

: UR: In this case, the patient is a with back, neck, and shoulder pain. The patient had 10 sessions and their pain went from 6/10 to 5/1. The patient is still on Tylenol 3, Flexeril, and Naprosyn. The PT notes indicate they had some improvement in ROM but no quantification was given and there is no indication of progression with psych issues. There is no indication of significant functional benefit or progression in the program warrant continuing. Therefore, the request is non-certified.

: Denial letter: Not medically certified by Peer Advisor.

:UR: This claimant is a female with a date of injury on xx/xx/xx. She was seen on with emotional psychological and

physiological symptoms resulting from her work injury. The report addresses her as a man and a woman. She participated in physical therapy. She feels her pain interferes with her communication. They discussed ways for her to deal with the pain. Her pain is 5-7/10. She reports symptoms of depression and anxiety. It was recommended she attended 10 sessions of chronic pain management. It was also noted that the claimant presented with chronic pain complaints in the right shoulder, neck, right knee and both hips. Her pain was 5/10 since last session in her right shoulder. The burning sensation is very strong. Her right elbow pain is 5/10. Her neck pain is 7/10. Pain in the right hip and leg is 6/10. She is taking Tylenol #3 3 times a day. She has difficulty sleeping due to pain. She was treated in aquatic therapy. It was reported that she had a positive attitude toward other patients and staff. It was noted her right shoulder ROM was increasing gradually but she was having difficulty extending/flexing as well as abducting her right shoulder. Biking exercises were done with more resistance than the last session. She had to take constant rest periods. Appeal is for additional ten sessions, 5x2 of chronic pain management is not medically necessary. I am unable to support the request for additional 10 days of chronic pain program. The current medical records are insufficient to justify medical necessity at the time. There is lack of objective metrics with respect to her functional capabilities before and after the first ten sessions of therapy. She has undergone psychiatric/psychological intervention but there is no discussion as to the outcome/residual deficits-concerns. There is no indication of anxiety or depression scores, pain avoidance/fear avoidance issues. There does not appear to be any significant improvement in her pain of medication usage. There is no indication what type of low back surgery she had. There is no comprehensive clinical exam post first 10 days of chronic pain program. For these reasons I am unable to support extending the program. Therefore appeal for additional ten sessions, 5x2 of Chronic Pain Management is not medically necessary.

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

Determination: denial of additional 10 sessions of chronic pain management program is UPHeld/AGREED UPON since there is lack of documentation of subjective and objective gains with the first 10 sessions.

There is no initial or progressive data reflective of decreased pain scores, decreased use of habituating medications (Tylenol # 3 and Flexeril), improvement in psychometric measures (such as screening scores for anxiety/depression/fear avoidance with physical activity), education in/application of pain/stress management techniques, improvement in functional activities including lifting abilities, and movement towards achieving specific goals particularly return to productivity. Therefore, the request for additional 10 sessions of chronic pain management program is not medically necessary.

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 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).

(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)