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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 10 Visits

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

This reviewer is a Board Certified Physical Medicine and Rehabilitation Doctor with over 20 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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]:

The claimant is a who was injured on while at his job and was diagnosed with lumbar sprain/strain.

Operative Report. **Pre-operative Diagnosis:** 1. Herniated nucleus pulposus, left side, L4-L5. 2. Herniated nucleus pulposus, right side, L4-L5. 3. Bilateral lumbar radiculopathy. **Surgical Procedures:** 1. Laminotomy, left side, L4-L5. 2. Discectomy, left side, L4-L5. 3. Laminotomy, right side, L4-L5. 4. Discectomy, right side, L4-L5.

Office Note. Patient was seen back in the office. He has been doing well after starting therapy. He has continued to have back pain, primarily on the left side, but it has not been associated with significant radicular symptoms. Examination showed tenderness in the left paraspinal muscles. He had pain with ROM. I did not detect any nerve root tension signs. There was normal strength in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus, gastrocnemius, and soleus group.

Progress note. **Subjective:** reports L sided low back pain with L leg radiating pain which is decreased with medication. He reports being in one position for an extended period of time increases the back pain. **Objective:** B L1-L5 L>R/ L T10-T12 paraspinal sprains, tenderness, lumbar flexion 60°, extension 10°, L lateral flexion 20°, R lateral flexion 15°- _____ ROM all planes. Core weakness. **Assessment:** No diagnosis change today. **Plan:** Follow. Follow up with Due to the significant delay regarding the lumbar surgery significant core weakness is delaying the post-surgical recovery. does continue to demonstrate improving flexibility/AROM with treatment but core weakness persists. I will pre-authorize an additional 8 sessions of therapy focusing on core strengthening.

Follow-up visit. has done well over the last four weeks. He has been undergoing therapy, and he has been doing an exercise program on his own. He still feels occasional giving way in his left-lower extremity when he walks. Examination today shows some tenderness in the left paraspinal muscles. He has some pain in his back with straight leg raising. There is normal strength in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus, gastrocnemius, and soleus group. The patient will continue doing an exercise program on his own. I gave him a prescription for additional pain medications. We will see him on an as-needed basis.

Follow-up visit. has completed therapy, and he is now doing an exercise program on his own. Despite this, he continues to have pain in his back with radiation down his left leg. The left-leg pain is truly radicular, going down past the level of the knee and into the foot. Examination today shows tenderness in the left sciatic notch. He has some discomfort with straight-leg raising. I do not detect any discrete motor weakness in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus, gastrocnemius, and soleus group. Because of his ongoing radicular complaints, I think it would be worthwhile obtaining an updated MRI scan of the lumbar spine with gadolinium enhancement.

Progress Note. **Subjective:** Low back pain radiating to the left leg ___ numbness c/ tingling -> 8/10. Neck pain and ___ pain->6/10 with numbness and tingling. **Objective:** Lumbar surgery. He did feel much better after surgery. Before surgery he received 2 EST _____. Lumbar sprains, tenderness. Lumbar end ROM pain. _____ B Hamstring tightness. **Assessment:** No diagnosis change. **Plan:** Follow up with. Pending approval for program recommends repeat lumbar MRI.

UR. **Rationale for Denial:** A peer to peer review could not be accomplished. At the present time, for the described medical situation, the above noted reference would not support this request to be one of medical necessity. Presently, this specific request would not appear to be of medical necessity as the submitted documentation does not provide sufficient data to indicate that all lesser levels of care have been exhausted. Given the fact that a peer to peer review could not be completed, presently, medical necessity for this request is not established.

UR. **Rationale for Denial:** As the requesting provider, you were provided a reasonable opportunity to speak with the physician advisor regarding your request prior to the determination being rendered. If you, the injured worker or their representative, or the facility rendering the service does not agree with the determination, an appeal can be requested within 30 calendar days of receipt of this letter.

Follow-up visit. was seen back in the office on I reviewed his MRI scan dated. There were postoperative changes at L4-5. There was a small central disc herniation with a posterior annular tear at L4-5, but there was no nerve root or thecal sac compression. This man has continued to have back pain with radiation into his legs, left much greater than right. The exam today was essentially unchanged. I explained to him that he has nothing for which to offer him surgery, but I did recommend ongoing pain management.

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

Denial of request for 10 visits of chronic pain management is OVERTURNED/DISAGREED WITH based upon review of submitted additional medical records including follow up visit dated for review of recent MRI both AFTER the previous UR's for this request. After review of the postoperative MRI had no other surgical interventions to offer and recommended "pain management." Also reviewed was an FCE dated notable for consistent/valid effort and current physical capability of SEDENTARY/LIGHT versus MEDIUM job demands. Also reviewed a behavioral evaluation dated with BDI of 32 (severe depression), BAI 37 (severe anxiety), FABQ PA 24/24, FABQ W 42/42, pain level 8/10, medications of Norco twice a day, Lyrica and Celebrex, motivation to return to work full time/full duty at same job with different employer, euthymic mood, Severe PSS and GAF 60 and recommendation of 10 sessions of interdisciplinary rehabilitation 8 hours a day, 5 days a week for 2 weeks. I also reviewed treatment plan of the program with specific goals regarding decreased pain, increased function, decreased psychometric measures, return to work plans and application of pain/stress management techniques. 10 visits of chronic pain management program are medically necessary and in accordance with ODG given 20 months of

chronic pain, exhausted lower levels of rehabilitation with postoperative basic Physical Therapy s/p bilateral L4-5 laminectomy/discectomy on no pending invasive procedures based upon recently reviewed lumbar MRI dated with continued functional deficits demonstrating SEDENTARY/LIGHT (15 lb.) capability versus MEDIUM (50 lb.) job demands, psychometric measures documenting severe depression/ anxiety/fear avoidance/sleep disturbance, persistent use of habituating opioid analgesic medication, and specifically outlined treatment goals including motivation to return to work.

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)