

# Health Decisions, Inc.

6601 CR 1022

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## Notice of Independent Review Decision

[Date notice sent to all parties]:

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Initial 80 hours (10 days) Chronic Pain Management Program (5x Per week for 2 weeks)

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** American Board Certified Anesthesiologist with experience in Pain management for over 6 years.

**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]:**

Patient is a female who sustained a work related injury. reported being injured on during her regular work related duties. She stated that she was xxxxx, injuring her legs, neck, upper back and shoulders. Past medical history: HTN, Asthma, Pancreatitis, diverticulitis and Hepatitis. Request is for : Initial 80 hours (10 days) Chronic Pain Management Program (5x Per week for 2 weeks)

06/25/13: Numerous XR results from patients chart: Pelvis 1-V: Exam of pelvis in single AP projections reveals no obvious bony abnormalities. Surgical clips are seen in the region of the pelvis.  
Left knee 3V: Exam of the left knee in AP and lateral projections reveal no obvious fracture. There is joint space narrowing involving the medial femorotibial joint space. I see no obvious chondrocalcinosis. Some fullness is seen in the suprapatellar region suggestive of joint diffusion. Right knee 2V: Exam of the right knee in AP and lateral views reveal no obvious fracture. Osteoarthritic changes involving the patellar femoral and medial femorotibial joint space. I see no other radiographic abnormalities. Left Tibia-Fibula – Exam of the left tib/fib in AP and lateral projections reveals no obvious fracture. Soft tissues appear normal. Right Tibia-Fibula 2V Exam of the right tib/fib in the AP and Lateral projections excluding the ankle joint, reveals no radiographic abnormalities.

07/25/13: MRI result of Cervical Spine without contrast: Conclusion: Disc osteophyte at C4-C5, C5-C6 levels on the left side with impingement on left C5 and C6 nerve root. Disc protrusions on the left side at C3-C4 level. Central spinal canal and foraminal stenosis at C4-C5, C5-C6 levels. Normal spinal cord.

09/26/13: Physical Therapy Functional Capacity Evaluation

11/21/13: Epidural Steroid Transformaina- cervical Procedure note: Pre and Post-operative diagnosis: Radiculitis Cervical/Brachial 723.4. Once discharge criteria were met, the patient was discharged home with escort and instructed to contact out office with any problems or concerns. Pt advised to return to our offices in 1-2 weeks for reassessment.

04/03/14: Epidural Steroid Transformaina- cervical Procedure note: Pre and Post-operative diagnosis: Radiculitis Cervical/Brachial 723.4. Once discharge criteria were met, the patient was discharged home with escort and instructed to contact out office with any problems or concerns. Pt advised to return to our offices in 1-2 weeks for reassessment.

05/01/14: Physical Therapy note: On a scale of 0 to 10. The patient's pain level at worst is a 8/10. The patient is currently reporting and average pain level of 4/10 the patients current pain level is 4/10. The patient reports that pain is located paracervical, suboccipital and into bilat upper extremities. This is a know to me from previous treatment following cervical injury. She was injured on about when she was xxxx. She has received injections by and reports that approximately one week after injection she had developed a burning sensation in her upper back and then developed tingling "everywhere". She is currently c/o xxxx and tingling in her upper extremities. She is taking medication of Tramadol and Lodine. She has quit her job. She is referred here for 2 visits. I assume for instruction in ex program for ROM and strengthening. She also reports that she is scheduled to see a designated doctor for an impairment rating. Plan of treatment: Will include but not be limited to evaluation, therapeutic exercise, and education 2 times a week for 1 week.

06/10/14: Physical Therapy note: Pt stated that they are asking for 10 more visits and that she might also have surgery. Pt instructed to perform HEP and performed the exercises correctly and seems to understand the importance of home exercise programs. Continue with the plan of care.

07/10/14: Office note: This is a consult visit. This is a female who suffered a work related injury on This patient reports that she was xxxx. This caused her xxxxx. This caused an acute onset of burning neck pain with radiation into the medial boarder for the left scapula into the left shoulder along the lateral arm into the first three fingers of the left hand with associated numbness and tingling in a similar distribution. The patient also describes associated severe headaches. She is status post physical therapy and epidural steroid therapy with no improvement in her symptomatology. She currently describes her pain level and a 5/10 on visual analog scale with worsening symptomatology following prolonged sitting, standing, and bowel or bladder dysfunction at this time. The patient denies a previous history of injury to the neck prior to said accident. Mental Status normal she is alert and orientated. Cervical range of motion was decreased in lateral rotation secondary to pain. Motor exam reveals Cervical radiculopathy, Herniated nucleus pulposus at C3-4, C4-5 and C5-6, Cervicalgia. Recommendations: Due to failure of conservative medical therapy including physical therapy and epidural steroid therapy, pain duration greater than six months, current neurologic status which evidence of the disc osteophytic complexes at C3-4, C4-5 and C5-6 paracentrally and toward the left with associated left sided foraminal stenosis and effacement of the C4, C5 and C6 nerves root sheaths on the left at this time I recommend Anterior cervical discectomy and fusion at C3-4, C4-5 and C5-6 with placement of anterior cervical plate.

09/08/14: Office note: The patient returns for follow up with no significant improvement in her previous symptomatology which includes neck pain with radiation into the medical boarder of the left scapula into the left shoulder along the lateral arm into the first three fingers of the left hand with associated numbness and tingling in a similar distribution. The patient also relates associated headaches. She continues to describe her pain label as a 6-7/10 on a visual analog scale with worsening symptomatology after prolonged sitting, standing, cough, sneezing or Valsalva maneuver. The patient also denies bowel or bladder dysfunction at this time. Cervical range of motion was restricted in lateral rotation secondary to pain. Motor exam reveals 4/5 strength of the deltoid, biceps and wrist extensors of the left, otherwise 5/5 throughout. Deep tendon reflexes were +1 in the biceps on the left, otherwise +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Gait: The patient had no difficulty with toe of heel walking. Tandem walk was within normal limits. Straight leg raising was not tested. Spurling's sign was positive bilaterally. Sensory exam reveals a hypoesthetic region over the C4,

C5, and C6 distributions on the left to pin prick and light touch, otherwise intact. Coordination was intact in finger to nose exam and rapid alternating movements. Impression: Cervical radiculopathy, Herniated nucleus pulposus at C3-4, C4-5 and C5-6, Cervicalgia. I described an anterior cervical discectomy and fusion at C3-4, C4-5, and C5-6 with placement of anterior cervical plate in detail including the possible complications, prognosis and morbidity and mortality. The patient understands the risks and is willing to proceed with surgical intervention at this time. She will require pre-op medical clearance and postoperative bracing.

09/11/14: Operative Report: Pre and Post-operative diagnosis: Cervical radiculopathy and Herniated nucleus pulposus at C3-C4, C4-C5, and C5-C6 no complications.

12/17/14: Office note: returns today for routine follow up and re-evaluation. Since the last visit there has been significant improvement in pain levels and distribution. She has an ACDF 9/11 with. Headaches are resolved but the dysesthesia in UE is still present. She reports adequate pain control on current medications and that they are well tolerated, without significant side effects. She is requesting refills of these medications without modification. There being no contraindication to the refill we will provide a maximum of a 90 day prescription. Pt given Norco 10mg-325mg 1 BID PRN and Ultram 50mg 1-2 tabs Q6h.

02/04/15: Office note: Pt visits this morning with neck pain that has gotten worse. The frequency of pain is daily. Her pain continues since her last visit, and her physical findings are unchanged. She is 5 months post ACDF and reports marked improvement in pain levels and mobility. She states she is going to retrain for a non-physical job through xxxxx. Pt advised to buy a travel pillow to use when sleeping. No medications are prescribed today she will return to our clinic as needed. Pt is oriented and nonantalgic gait; ambulates without difficulty. Plan is to stay on current medications and treatment regime without modifications. Continuing conservative care only is indicated. No additional diagnosis studies interventions or referrals are anticipated at this time. Pt is to continue with home exercise program if applicable.

04/21/15: Office note: Pt returns today for routine follow up and re-evaluation. Since the last visit there has been no significant change in pain levels or distribution. Had a DD exam and received a 15% WP IR. DOI. Pt is not working, will refer to for assessment. She reports adequate pain control on current medications and that they are well tolerated, without significant side effects. She is requesting refills and they will be provided. No other changes.

04/24/15: Psychotherapy Treatment Plan note by, MA, NCC, LPC: Diagnosis: Pain Disorder Associated with both Psychological factors and a general medical Condition. This therapist recommends that attend the Chronic Pain Management Program to assist in her long-term rehabilitation. This includes Cognitive Behavioral Group Therapy as well as physical rehabilitation. Completion time frame: 10 days of Chronic Pain management program.

06/17/15: Functional Capacity Evaluation: Recommendations: has struggled with his work related injury since. She is seeking both physical and emotional rehabilitation opportunities with. Client's psychological evaluation indicates moderate depressive symptoms and severe anxiety. would benefit from a supervised program that would afford her an opportunity to work through emotional, thought and behavioral issues which impact her medical condition. This program would likely decrease risk for suffering and further disability as well as improve her chances for a positive long-term physical rehabilitation. This client appears to be acceptable for a comprehensive rehabilitation program.

07/31/15: Psychological Evaluation for Chronic Pain management program: Recommendations: The patient was injured on xx/xx/xx when she was xxxxxx. She has 1 month of physical therapy and reports working light duty with a 20 lb lifting restriction. She has made mild improvements with physical therapy but has not recovered enough to work without restriction. She is experiencing symptoms consistent with neural compression and the results of the MRI. Continue her physical therapy. Re-evaluating her function in another month is recommended. If no further treatment is authorized she may benefit from an injection. She is not ready for work conditioning at this time.

08/28/15: Peer Review Report: The request for initial 80 hours (10 days) is not medically necessary. There is no indication what meds she is taking. There is no indication what treatment she had after her neck fusion. She had an

old FCE, No date that had her performing at light/med PTL but now she is at sedentary with no explanation as to why. A pain program is a tertiary level of care and it is not clear that she needs it for medication detox or that she failed lower levels of treatment.

09/03/15: Peer Review Report: A chronic pain management program for the cervical spine, five times per week for 2 weeks for a total of 80 hours is not medically necessary.

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

The request for initial 80 hours (10 days) is not medically necessary. There are no indications as to the claimants pharmacologic therapy. Additionally, there is no indication what treatment(s) she has had after her neck fusion. Claimant has an FCE that had her performing at light/med PTL but the claimant is now sedentary. A chronic pain management program for the cervical spine is a tertiary level of care and it is not clear that she needs it for medication detox or that she failed lower levels of treatment. Therefore, this request is non-certified.

**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)**