



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WCN

DATE OF REVIEW: 3-20-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Interdisciplinary Pain Management Program 10 sessions (5 x a week for 2 weeks) = 80 hours

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

American Board of Anesthesiology and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 12-17-08 Functional Capacity Evaluation.
- 1-21-09 RN, CNS-BC., performed a clinical interview.
- 2-9-09 MD., provided a Utilization Review non-certification.
- 2-12-09 MD., provided a request for reconsideration letter.
- 2-24-09 DO., provided a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 12-17-08, a Functional Capacity Evaluation was performed by DC., which demonstrated the claimant was functioning in a Medium PDL level.

1-21-09 RN, CNS-BC., performed a clinical interview. It is noted the claimant is a male who was referred by referred by his neurosurgeon, regarding significant pain that has been persistent and prominent since a work-related injury that occurred on xx/xx/xx, while employed. On the date of injury, the claimant sustained an injury to the lumbar back. He was working on a truck and leaning over the back bumper, attempting to reattach a hatch bolt when suddenly felt an incredible, stabbing pain throughout his lower back. He went to the emergency room where he saw Dr. He was given some medications; however, no diagnostic tests were ordered. He eventually saw Dr. who became his treating doctor. He was sent to physical therapy ; however, he did not see any improvement there. He eventually was referred to Dr. A MRI revealed a herniated lumbar disk. Dr. performed a L4-L5 microdiscectomy on July 25, 2008. He recovered without complications; however, he continued to have rather significant pain. He also had ESIs, which did not offer him any relief. Eventually, he was referred to a pain management program. Upon evaluation of the claimant's current condition, the evaluator noted that it has become apparent that he has exhausted all acute medical treatment and testing related to his injury. The claimant's treating doctor requested an evaluation to determine his need for a return-to-work program, which includes a clinical interview to determine whether the claimant would be appropriate for admission to and participation in an interdisciplinary chronic pain management program, as well as to determine any other treatment needs. The claimant's chief complaint at the time of the interview was that he was limited in what he did due to pain. It affects his walking, standing, and driving. The claimant also reports the pain radiates to his legs and he also has stabbing pain in the neck. A mental status assessment was performed, as well as a Beck Depression Inventory, and Beck Anxiety Inventory. The results of this

assessment suggest that the claimant is experiencing persistent pain that exacerbates the psychological distress manifested by sleep disturbances, a threat to his ability to continue working and frustration with debilitating pain that at this point is threatening his present lifestyle. To help the claimant control his level of distress and pain and maximize his ability to continue working and sustain a productive lifestyle, it is recommended that he be admitted to an Interdisciplinary Pain Management Program to increase appropriate coping skills for pain and stress management. A cognitive-behavioral approach with emphasis on relaxation skills, behavioral modification for sleep disturbance, and cognitive challenging to address issues related the hopelessness and helplessness he experiences when coping with his pain would greatly benefit the claimant. The recommended clinical services would enable him to learn to cope with pain in a more effective way and prevent further development of his feelings of disability. The therapy will maximize his chances for return to a more optimal level of functioning and an enhanced quality of life. The evaluator recommended that the claimant be admitted to the Interdisciplinary Pain Management Program for 10 days, 8 hours a day. During the first 10 days, a review of progress will be made. If treatment goals are being met, then additional sessions may be recommended. If treatment goals are not being met, other options will be considered at that time based upon his general level of functioning. Diagnostic Impression: Axis I: 307.89 Pain Disorder Associated with Psychological Factors and a General Medical Condition. Axis II: 799.9 Deferred Axis III: 722.1 724.2 724.3. Axis IV: Psychosocial Stressors: 3, Moderately severe Chronic Pain producing disruption of psychological function, unemployed Financial stressors. Axis V: GAF: Current: 55%.

2-9-09 MD., provided a Utilization Review non-certification. The evaluator noted that the recommended treatment is an end all type of intensive program. Other interventional therapy of any type should be ruled out prior to entrance in this program. Records do not reflect the claimant meets this criterion.

On 2-12-09, MD., provided a request for reconsideration letter. The evaluator recommended that reconsideration for the claimant to participate in an Interdisciplinary Pain Management Program for 10 sessions, 5 times a week for 2 weeks, a total of 80 hours. The program will measure progress and response to treatment. The claimant is motivated to attend the program and participation will enhance his ability to regain his previous lifestyle as well as to expedite return to work. In making this recommendation, the evaluator certified that participation in a Pain Management Program is of medical necessity and will assist in the obtaining relief from the effects naturally resulting from his injury as well as promote recovery and enhance his ability to return to work following the program.

2-24-09 DO., provided a Utilization Review for reconsideration of previous non-denial for the pain management program. The evaluator reported that the clinical information submitted fails to meet practice guidelines for the requested service. Guidelines state that previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. There is inadequate documentation that conservative options have been exhausted to address

the pain generators post surgery. The clinical record states an ESI was performed prior to surgery without success. There is no indication of post surgical procedure. There is indication that lower extremity paresthesias are persistent post surgery. Conservative measures to address this are not noted other than the use of Flexeril, Darvocet and Ibuprofen, which are not specific for paresthesias pain. Neurological examination of the lower extremities indicates no focal sensory deficits and symmetrically equal reflexes. It was also interesting to note that the FCE test indicates the claimant is capable of Medium-Light PDL.

3-18-09 additional records were requested as there was no information regarding the claimant's evaluation performed by the Treating Doctor detailing the claimant's current status, physical findings, history, current treatment, past treatments, and medications and why he is recommending this treatment.

On 3-18-09, a phone call was made by IRO to Back Clinic at 11:09 am requesting additional information. She said Mr. is relatively new to their office and previous provider has recommended pain management program. Mr. had been seen in their office and then Mr. 's wife was undergoing breast cancer treatment and her condition worsened so he hasn't been in that much recently. She believes a Dr. is providing Mr. with his medications and she will call his office to see if she can get any records. She said she would see what other records she has and fax them today or tomorrow.

In 3-20-09, no additional information had been received.

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

Additional records would need to be reviewed in order to approve the requested treatment. The information currently provided does not support a chronic pain management program. There is inadequate documentation that all other therapies had been exhausted. In order for there to be strong consideration for this therapy, more thorough documentation would be needed. According to ODG-TWC, a chronic pain program is appropriate if a claimant has a significant loss of ability to function independently resulting from the chronic pain; previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; the claimant is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided. There is an absence in documentation that the claimant meets the criteria set forth in The Guides to have a successful outcome for the recommended treatment.

ODG-TWC, last update 2-19-09 Occupational Disorders for Pain – Chronic pain program:

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

(1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;

(2) The patient has a significant loss of ability to function independently resulting from the chronic pain;

(3) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;

(4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided;

(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;

(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;

(7) Negative predictors of success above have been addressed;

(8) These programs may be used for both short-term and long-term disabled patients. See above for more information under Timing of use;

(9) 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 these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program;

(10) Total treatment duration should generally not exceed 20 full-day 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 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function; (11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) is medically warranted for the same condition or injury. 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.

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 KNOWLEDGBASE
- 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)**