



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 09/14/09

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: 10 sessions of chronic pain management rehabilitation

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

Texas Licensed Psychologist

**REVIEW OUTCOME**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Progress note dated 11/16/07.
2. Progress note dated 11/26/07.
3. Physical therapy progress note dated 11/28/07.
4. Progress note dated 12/03/07.
5. Progress note dated 12/04/07.
6. therapy initial evaluation dated 12/04/07.
7. Progress note dated 12/10/07.
8. Physical therapy progress note dated 12/26/07.
9. Progress note dated 12/26/07.
10. Progress note dated 01/02/08.
11. Progress note dated 01/15/08.
12. Gastroenterology consultation dated 10/23/08.
13. MRI lumbar spine without contrast dated 10/28/08.
14. MRI brain with and without contrast 10/28/08.

15. CT angiogram of head dated 11/07/08.
16. Letter dated 12/10/08.
17. EMG/NCV dated 12/10/08.
18. Neurology consult dated 01/09/09.
19. EMG/NCV of lower extremities dated 01/09/09.
20. Follow-up note dated 01/15/09.
21. Follow-up note dated 01/29/09.
22. work status report dated 02/06/09.
23. Follow-up note dated 02/12/09.
24. initial evaluation dated 02/23/09.
25. Peer review of medical records dated 03/03/09.
26. Comprehensive medical analysis dated 03/04/09.
27. Follow-up note dated 03/12/09.
28. Follow-up visit dated 03/19/09.
29. Previous utilization review dated 03/30/09.
30. Follow-up report dated 04/09/09.
31. Initial interview for chronic pain management program dated 04/21/09.
32. Follow-up visit dated 04/29/09.
33. Follow-up report dated 04/30/09.
34. Follow-up report dated 06/05/09.
35. t individual therapy progress note dated 06/16/09.
36. t individual therapy progress note dated 06/23/09.
37. t individual therapy progress note dated 06/25/09.
38. t individual therapy progress note dated 06/30/09.
39. Request for chronic pain management program dated 06/30/09.
40. Functional Capacity Evaluation dated 07/16/09.
41. Adverse determination notice dated 07/23/09.
42. Request for reconsideration dated 07/29/09.
43. Adverse determination after reconsideration notice dated 08/06/09.
44. Request for medical dispute resolution dated 08/31/09.
45. **Official Disability Guidelines**

#### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a xx year old male whose date of injury is listed as xx/xx/xx.

The earliest clinical record provided was a gastroenterology consultation dated 10/23/08. The employee presented with severe back pain status post a fall, and recently the employee has been unable to work his job as .

The employee underwent an MRI of the lumbar spine and an MRI of the brain on 10/28/08, followed by CT angiogram of the head on 11/07/08. The employee has a

history of hypertension, arrhythmias, Guillain-Barre syndrome, neuropathy, hypercholesterolemia and hypothyroidism. The employee reports that in 2005 he had symptoms of numbness and weakness and was diagnosed and treated with Guillain-Barre syndrome. The employee improved and did well until relapse in 2007. The employee returned to work after a second round of physical therapy. The employee reported that on the date of injury he fell backwards at work and began to experience severe pain in his lower back radiating to the lower extremities. The employee reported that since that time he had progressive worsening of weakness and giving out of his legs and increasing falls.

The employee underwent an EMG/NCV of the lower extremities on 12/10/08.

The employee subsequently underwent neurological examination on 01/09/09. The diagnoses were reported as lumbar radiculopathy and chronic back pain secondary to the fall. The employee underwent another EMG/NCV of the lower extremities on 01/09/09.

A follow-up note dated 01/15/09 indicated that the employee complained of being unable to sleep and additional diagnosis of posttraumatic stress disorder was reported. The employee received an injection of Robaxin, B12 and Depo-Medrol on 01/29/09.

A follow-up note dated 02/12/09 indicated that the employee had been responding well to injections and stated the symptoms were a little better. The employee was provided prescriptions for Cymbalta, Ultram ER and Amrix.

The employee underwent an initial orthopedic evaluation on 02/23/09. Treatment to date includes diagnostic testing, physical therapy, injection therapy, and medication management. The employee had not been able to return to work since September of 2008. The diagnoses were listed as bilateral ligamentous injury of both wrists, rule out bilateral scapholunate disassociation, and lumbosacral strain superimposed onto the degenerative disc disease of the lumbosacral spine. The employee was started on a Medrol Dosepak, Clinoril, Robaxin, and Fiorinal.

A peer review was performed by Dr. on 03/03/09. Dr. reported that the submitted records and the mechanism of injury did not support any injury to the back or the neck. The employee reportedly sustained a mild to mild-moderate sprain to the right wrist, and no permanent injury was sustained. Dr. reported that he "would have a significant index of suspicion" regarding the diagnosis of posttraumatic stress disorder based on general medical experience, noting that the trauma experienced was not great and "one does not usually see posttraumatic stress disorder with injuries of this type". The employee underwent a psychological evaluation to determine appropriateness for a chronic pain management program on 04/21/09. Treatment to date included x-rays, MRI, physical therapy, pain injections, aquatic therapy, and medications, and none have been completely successful in lowering his levels of pain. The employee's psychological symptoms include sadness/down, hopelessness, insomnia, frustration, irritability, short temper, and fear of reinjury. Current medications were listed as Oxycodone, Darvocet, and Vicodin. The employee reports feelings of depression and anxiety, as well as experiencing a high level of stress. The diagnosis was reported as chronic pain disorder associated with both psychological factors and a general medical

condition. The Beck Depression Inventory was reported as 12 and Beck Anxiety Inventory was 26. The employee was subsequently recommended for ten sessions of a chronic pain management program, as the employee "has not been able to become stabilized enough to improve coping mechanisms to more effectively manage pain while executing activities of daily living".

A records review performed on 03/30/09 indicates a gap in treatment from January 2008 to January 2009. The employee completed four sessions of individual psychotherapy in June 2009. The Beck Anxiety Inventory reportedly decreased from 26 to 25.

A Functional Capacity Evaluation (FCE) dated 07/16/09 reported that the employee's required physical demand level was medium-heavy and his current physical demand level was below sedentary.

An adverse determination notice dated 07/23/09 indicated that the employee had undergone two recent peer reviews and a chronic pain management program was twice non-certified noting that the employee does not meet criteria for a chronic pain management program. The peer review reported that the employee's industrially related injury was a strain/sprain of the wrist/forearm which had resolved. The employee has been returned to full duty at least twice during this clinical course. The second review by a pain management specialist reported that the employee did not have posttraumatic stress disorder and the status of the employee was not known from 12/10/07 to 04/21/09. The employee was previously placed at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. An adverse determination after a reconsideration notice dated 08/06/09 reported that previous denials indicated lower levels of care had not been completed, and the employee had previously been placed at MMI with a 0% impairment rating.

A request for medical dispute resolution dated 08/31/09 indicated that the employee had "exhausted all lower levels of care including individual psychotherapy".

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

Based on the clinical information provided, I am in agreement with the previous reviewers that ten sessions of chronic pain management sessions is not medically necessary for this employee. There is no stable diagnosis for this employee. The submitted records indicate a diagnosis of posttraumatic stress disorder; however, as previously stated by Dr. , there is no trauma to support this diagnosis. The employee has also been diagnosed with Guillain-Barre syndrome which is an auto-immune disorder that causes significant pain. There is no indication that the employee has exhausted lower levels of care as required by evidence based guidelines. The employee's date of injury is xx/xx/xx and the submitted records begin on 10/23/08. There is no comprehensive assessment of conservative treatment completed to date or the employee's response thereto. The employee's compensable injury appears to be a sprain/strain to the right wrist which has resolved. There is no indication in the submitted records that the employee's right wrist sprain/strain is responsible for the employee's inability to return to work at this time. Given the lack of a stable diagnosis,

lack of lower levels of care, and concurrent diagnosis of Guillain-Barre syndrome, the employee does not meet inclusion criteria for a chronic pain management program and is not a suitable candidate for this tertiary-level program at this time. Based on the clinical information provided, ten sessions of chronic pain management is not considered medically necessary for this employee.

## **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

### ***Official Disability Guidelines*** Pain Chapter

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.

(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 20 full-day (160 hours) 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 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. 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](#).