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DATE OF REVIEW: 09/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO - Chronic Pain Management 5 x wk x 2 wks; 10 sessions 5 x 2

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

This case was reviewed by a Texas licensed MD, specializing in Psychiatry. The physician advisor has the following additional qualifications, if applicable:

ABMS Psychiatry and Neurology: Pain Medicine, Psychiatry and Neurology: Psychiatry, Psychiatry & Neurology: Forensic Psychiatry

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO - Chronic Pain Management 5 x wk x 2 wks; 10 sessions 5x 2	97799	-	Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

There were 99 pages reviewed. The claimant is a female with a date of injury of xx/xx/xx. The request is for a Chronic Pain Program, IRO review. A Designated Doctors Exam was performed on 7/15/09 in which a

MRI dated 05/02/08 was reviewed. The MRI findings showed a Central L5-S1 disc herniation with severe degenerative disease. The disc material touches both S1 nerve roots as well as broad based left foraminal

and far lateral space annular bulges at L4-5 and L3-4. A functional capacity exam dated 4/1/09 found sedentary capacity with work restrictions. Pain levels are described as 6/10, worse at night. Subjective

radiculopathy was present and there were no Waddell signs. The claimant had received no specific treatment for the herniated disc at L5-S1 and was not at Maximum Medical Improvement (MMI). Office notes indicate an epidural steroid injection (ESI) was denied on 3/9/09. The 6/30/09 note finds the claimant on

Norco, Mobic, Neurontin, Zanaflex and Ultram. The 7/28/09 note mentions past treatment with injections but does not indicate what type, when, or response and to what body part. Previous reviews for a Chronic Pain Program were denied on initial and appeal review for failure to demonstrate improvement in therapy, a worsening of symptoms in work hardening, an absence of clear medical documentation and an absence of documentation to show a reduction in pain medication as well as an absence to document specific

treatment goals and outcomes. The initial diagnostic screening of 6/10/08 diagnoses the claimant with adjustment disorder with mixed mood and pain disorder with psychological factors and a physical condition. Additional documentation per the diagnostic screening from 06/10/08 includes documentation of the claimant's

previous 10 sessions of psychotherapy but without response to the treatment and then under the mental health section of the report it states the claimant has not had any psychological or psychiatric treatment for

her work injury. The 6/16/09 request by Ms. lists again the diagnoses and also notes the claimant met with a psychologist who recommended skill based therapy and referral to a psychologist. The diagnosis was Major Depression Disorder (MDD). A section stating general treatment goals for this patient for a chronic pain program is also attached.

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

The most recent Designated Doctor Exam (DDE) indicates the claimant has not had specific treatment for the herniated lumbar disc and is not at Maximum Medical Improvement (MMI). The records sent following that exam do not identify the specific treatments the claimant has received following the DDE for the lumbar disc herniation. Additionally, there is no evidence that the claimant has been tried on tricyclic antidepressants for the treatment of the identified depression and chronic back pain. The records received indicate the claimant has had injections, but the type, frequency, date of injections and response are not clearly documented to determine her response or lack of response or even if other injections were considered and requested. Also, the diagnosis of depression and by one psychologist, Major Depression, is documented, but the records fail to show treatment for this depression through cognitive therapy or medication management. The request for a Chronic Pain Program does not meet the Official Disability Guidelines (ODG) because there is a failure to show that there is an absence of other options likely to result

in significant improvement and the request for a Chronic Pain Program does not carefully review her specific past treatments with responses (or lack of responses) as well as reasons why this claimant can not receive

significant clinical benefit for her depression and chronic pain by tricyclic antidepressants with or without cognitive behavioral therapy.

Chronic low back pain: Tricyclic antidepressants can produce moderate symptom reduction for patients with chronic low back pain.

Antidepressants: Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. ([Feuerstein, 1997](#)) ([Perrot, 2006](#)) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. ([Saarto-Cochrane, 2005](#)) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of antidepressants may be undertaken. ([Perrot, 2006](#)) ([Schnitzer, 2004](#)) ([Lin-JAMA, 2003](#)) ([Salerno, 2002](#)) ([Moulin, 2001](#)) ([Fishbain, 2000](#)) ([Taylor, 2004](#)) ([Gijnsman, 2004](#)) ([Jick-JAMA, 2004](#)) ([Barbui, 2004](#)) ([Asnis, 2004](#)) ([Stein, 2003](#)) ([Pollack, 2003](#)) ([Ticknor, 2004](#)) ([Staiger, 2003](#)) Long-term effectiveness of anti-depressants has not been established. ([Wong, 2007](#)) The effect of this class of medication in combination with other classes of drugs has not been well researched. ([Finnerup, 2005](#)) The "number needed to treat" (NNT) methodology (calculated as the reciprocal value of the response rate on active and placebo) has been used to calculate efficacy of the different classes of antidepressants. ([Sindrup, 2005](#)) See also the [Stress/Mental Chapter](#): Antidepressants for the treatment of depression. Also see Comorbid psychiatric disorders.

Specifically studied underlying pain etiologies: (also see below for specific drugs)

Neuropathic pain: Recommended (tricyclic antidepressants) as a first-line option, especially if pain is accompanied by insomnia, anxiety, or depression. ([Saarto-Cochrane, 2007](#)) ([ICSI, 2007](#)) Other recent reviews recommended both tricyclic antidepressants and SNRIs (i.e. duloxetine and venlafaxine) as first line

options. ([Dworkin, 2007](#)) ([Finnerup, 2007](#))

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks

- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual session)

Radiculopathy: There are no medications that have been shown to be efficacious for treatment of lumbosacral radiculopathy. ([Dworkin, 2007](#))

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](#)

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

ODG:

chronic pain program; herniated nucleus pulposus without myelopathy lumbar and thoracic disc ; chronic low back pain