



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: March 23, 2010

IRO Case #:

Description of the services in dispute:

Chronic Pain Management for 8 hours daily x 10 days.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Physical Medicine and Rehabilitation. This reviewer has been in active practice since 2005.

Review Outcome

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

Upheld

The request for 10 days of a chronic pain management program is not medically necessary at this time. The clinical documentation submitted for review indicates the patient is being treated with 800 mg of Ibuprofen secondary to constant 4-5/10 low back pain. The clinical documentation fails to indicate that the patient's pain level could be reduced with medication management to include possible narcotics. The patient is noted to have only completed 12 sessions of physical therapy to date. It is noted that clinical documentation indicates that previous requests for epidural steroid injections and individual psychotherapy have been denied. ODG Guidelines state that chronic pain management programs are warranted when "previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." As the patient has not exhausted all lower forms of conservative care to date, there is not an absence of other options likely to result in significant clinical improvement.

Information provided to the IRO for review

Records received from Texas Department of Insurance:

Notice of case Assignment 3/8/10, 1 page

Confirmation of receipt of a Request for a Review by an IRO 3/5/10, 5 pages

Request Form Request for a Review by an IRO 3/4/10, 3 pages

Preauthorization Request 3/4/10, 1 page

Notice of Assignment of IRO 3/8/10, 1 page

Request Form Request for a Review by an IRO 3/4/10, 3 pages

Preauthorization Request 3/4/10, 1 page

Request for review by an IRO 3/2/10, 5 pages

Request for Reconsideration 2/23/10, 6 pages
MD. Visit Note 2/18/10, 3 pages
Patient Progress Notes 10/28/09, 1 page
Review Determination 2/11/10, 4 pages
Review Determination 2/11/10, 4 pages
Request for Reconsideration 2/2/10, 5 pages
Review Determination 1/28/10, 5 pages
Behavioral Medicine Evaluation 1/21/10, 9 pages
Physical Therapy Goals 1/21/10, 2 pages
Exam Notes 1/21/10, 3 pages
Request for Pre-Authorization 1/14/10, 1 page
Functional Capacity Evaluation 1/13/10, 17 page
Physical Assessment Evaluation and Treatment Plan 1/11/10, 2 pages
MRI Report 8/26/09, 1 page
Weekly Schedule, 2 pages
Records received from Medical Operations Unit:
Case Notes 1/27/10 – 3/6/09, 2 pages
Supplemental Treatment Request 2/19/10, 1 page
Case Notes 2/12/10, 1 page
Office Note, 1/13/10, 1 page
MRI Report 8/26/09, 1 page

Patient clinical history [summary]

The patient is a male who sustained an injury on xx/xx/xx. MRI of the lumbar spine dated 08/26/09 reports evidence of a 1.2 mm disc bulge at the L4–5 level and a 3.5 mm broad based disc bulge at the L5–S1 level. A clinic note dated 10/28/09 reports the patient complains of back pain that radiates to the left lower extremity with associated numbness. A physical exam reports limited range of motion, tenderness at the left sciatic notch, positive right straight-leg raise and decreased sensation in the L5 distribution on the left. A clinic note dated 01/11/10 reports the patient was injured lifting a 300 lb. generator when he felt immediate pain and a pop in his back. The note reports the patient has completed 12 total sessions of physical therapy to date. Functional capacity evaluation summary dated 01/13/10 reports the patient has a current PDL (physical demand level) of sedentary and requires a PDL of heavy to return to full duty. A clinic note dated 01/21/10 reports the patient complains of low back pain that radiates into the left lower extremity with associated numbness and tingling. The note reports the patient is currently taking Ibuprofen 800 mg. A physical exam reports moderate tenderness to palpation at the L5–S1 paraspinals, 40 degrees of flexion, 10 degrees of extension, 28 degrees of side bending, 60 degrees of rotation, mild tenderness on the left sacroiliac joint, positive bilateral straight-leg raise, 5/5 motor strength, sensation to light touch intact and 2+ deep tendon reflexes. A behavioral medicine evaluation dated 01/21/10 reports the patient was previously recommended for 6 sessions of individual therapy; however, it was denied. The note reports the patient has a BDI (Beck Depression Inventory) –2 score of 23 and a BAI (beck Anxiety Inventory) score of 31. The patient was recommended for an

interdisciplinary pain management program. A prior review dated 01/28/10 reports the request for chronic pain management program was denied secondary to questionable FCE (functional capacity evaluation) results and the patient only taking Ibuprofen medication. The note also reports that peer-to-peer conversation revealed that the requesting physician recommends the patient for a work conditioning or work hardening program; however, as he does not have a job to return to, he is being requested for a chronic pain management program. A letter of reconsideration dated 02/02/10 reports that the patient's pre-test heart rate was 66 beats per minute and was elevated to 90 beats per minute after performing required tasks. The patient was again recommended for a chronic pain management program. A prior review dated 02/11/10 reports the request for chronic pain management was denied secondary to the patient only taking Ibuprofen medication and lack of response to previous attempts of medical treatment. A letter of reconsideration dated 02/23/10 reports the prior peer review was inaccurate in the statement that lesser levels of care have not been attempted. The note reports that the prior requests for individual counseling and lumbar epidural steroid injections were denied by the carrier. The note reports that all conservative interventions have been exhausted or denied. The note reports that the patient has a constant pain level of 4-5 which does not require strong narcotic medication. The patient was again recommended for a chronic pain management program. A request for review by IRO dated 03/02/10 reports the patient was recommended for an interdisciplinary chronic pain management program.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The request for 10 days of a chronic pain management program is not medically necessary at this time. The clinical documentation submitted for review indicates the patient is being treated with 800 mg of Ibuprofen secondary to constant 4-5/10 low back pain. The clinical documentation fails to indicate that the patient's pain level could be reduced with medication management to include possible narcotics. The patient is noted to have only completed 12 sessions of physical therapy to date. It is noted that clinical documentation indicates that previous requests for epidural steroid injections and individual psychotherapy have been denied. ODG Guidelines state that chronic pain management programs are warranted when "previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." As the patient has not exhausted all lower forms of conservative care to date, there is not an absence of other options likely to result in significant clinical improvement. As such, medical necessity for chronic pain management has not been established at this time.

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).