

Becket Systems

An Independent Review Organization
13492 Research Blvd. Suite 120-262
Austin, TX 78750-2254
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Management Program 5xwk x2wks

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

2/19/10, 3/18/10

MRI Lumbar spine, 05/27/08

Initial Evaluation, Dr. 06/26/08

Consult, LPC, 07/14/08

Office notes, Dr. 07/28/08, 08/25/08, 09/09/08, 09/22/08, 10/06/08, 11/03/08, 12/01/08, 01/05/09, 02/02/09, 03/03/09, 05/04/09, 05/18/09, 06/15/09, 07/20/09, 08/11/09, 09/21/09, 10/05/09, 11/02/09, 11/30/09, 12/28/09, 01/25/10, 02/15/10, 03/01/10

Lumbar Myelogram with CT scan, 12/12/08

Evaluation for Chronic Pain Management Program, LPC, 02/03/10

Physical Performance Evaluation, Dr. 02/05/10

Office note, Dr. 02/09/10

Request for Chronic Pain Management Program, 02/16/10

Peer review, Dr. 02/19/10

Reconsideration of Request for Chronic Pain Management Program, 03/12/10

Peer review, Dr., 03/18/10

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Update

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related injury to her low back on xx/xx/xx. A co-worker was lifting a pallet and knocked it into a cart which hit the claimant in the back and pushed her up against a conveyor trolley causing the claimant to have immediate severe back pain. She subsequently developed pain going down her left leg. The claimant had a 2 level lumbar fusion in 1995. An MRI of the lumbar spine on 05/27/08 revealed bilateral

spondylolysis at L5 with Grade I-II spondylolisthesis of L5 on S1. The degree of slip measured 1-1.2 centimeters. There was moderate left and mild to moderate right neural foraminal narrowing. There was mild degenerative spondylosis at L3-4 and L4-5. The claimant began to treat with Dr. on 06/26/08 and on examination had paravertebral spasm and tenderness of the lumbar spine, decreased range of motion on flexion, extension and rotation, lumbar myospasms and lumbar myositis. She had positive straight leg raising with numbness, tingling and dysesthesia in her left lower extremity. Dr. initially recommended no work for 30 days, physical therapy, EMG/NCV of her lower extremities, neurosurgical and pain management referrals and prescribed Lyrica and Darvocet N.

The claimant underwent a Behavioral Medicine Consult on 07/14/08 and it was felt that the claimant would greatly benefit from individual psychotherapy to assist her in developing tools and skills for pain management. The claimant had 12 psychotherapy sessions and still exhibited high fear avoidance levels. An EMG/NCV of the claimant's lower extremities was reported as normal. Physical therapy failed to help the claimant's symptoms. A Lumbar Myelogram with CT scan, done on 12/12/08, showed grade I/II lytic spondylolisthesis of L5 on S1. It showed the prior posterolateral fusion with bone graft material. There was suspected to be an incomplete osseous fusion across the L5 pars defects. There was left greater than right neural foraminal stenosis at L5-S1. Surgery was denied, as was a pain management consultation. The claimant was felt to have reached maximal medical improvement and was assigned an impairment rating in October of 2008. A Physical Performance Evaluation on 02/05/10 indicated that the claimant was able to work at the sedentary-light physical demand level and her functional strength deficit was 70.0 percent. A chronic pain management program was recommended as the claimant was not a surgical candidate. A request for a chronic pain management program has been denied twice. The claimant has remained under the care of Dr. and there has been no evidence of any attempts to wean the claimant off of some of her medications. She continued to take Darvocet, Lyrica, Tramadol and Trazodone and rate her pain as 8/10.

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

The requested chronic pain management five times a week for two weeks is medically necessary, based on review of this medical record. This is a 50 year old woman with ongoing chronic pain, since an injury in xxxx. The medical record offered for review documents an MRI with spondylolisthesis. There are multiple records from Dr. that document her pain complaints, positive physical findings and lack of improvement with conservative care. There is a 07/1/08 initial behavioral medical consultation with Dr. which would seem to indicate that she was improving. There is a 12/12/08 lumbar CT myelogram documenting L5-S1 changes. The patient has chronic pain with apparent failure of other appropriate conservative care. The ODG criteria for the general use of multidisciplinary pain management programs is met in this case. The reviewer finds that medical necessity exists for 97799 Chronic Pain Management Program 5xwk x2wks.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Update

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.

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

ACOEM-AMERICA 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)