Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 08/02/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a chronic pain management program five times per week for 2 weeks (80 hours).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 15 years and performs this type of service in their office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a chronic pain management program five times per week for 2 weeks (80 hours).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Unimed and the patient

These records consist of the following (duplicate records are only listed from one source): 5/6/10 preauth request, 5/11/10 denial letter, PT ODG guidelines, 4/28/10 rehab goals sheet, 4/28/10 FCE report, 5/24/10 reconsideration request letter, 3/2/10 re-evaluation report by Dr., 3/2/10 outcome grid, 3/2/10 treatment plan, 3/2/10vocational assessment note and 3/2/10 request for CPM program.

Patient: 2/9/09 lumbar MRI report, 8/18/09 report by MD, 7/17/09 statement by DC, DWC 41 of 1/21/09, 8/21/09 denial letter, 3/16/09 denial letter, 7/30/09 office note by MD, 8/3/09 neurodiagnostic report, 9/2/09 condition report sheet by Community Hospital, 9/3/09 low back radiographic report, 9/2/09 ER records, financial agreement between and the patient, 1/12/09 script for PT, PT notes 1/2/09, PT flowsheet 1/20/09 to 2/6/09, treatment plan 1/12/09 to 2/6/09, DWC 48 12/14/09 to 3/2/10, PLN11 of 3/6/09 and 6/16/09 reports by MD.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury to the lower back on xx/xx/xx. He reported that he was at work pulling nails from some flooring and then lifting the plywood. Pain developed in the lower back and in the left lower extremity. He was evaluated by Dr. and received

outpatient physical therapy. According to the therapy records the treatment program included aquatic therapy and instructions in a home exercise program.

MRI of the lumbar spine 02/09/09 was reported by, M.D. to show degenerative disc disease of L2-L3, L3-L4, and L4-L5, with broad-based disc protrusion at L4-L5. At the L4-L5 level the right neural foramen is moderate to severely narrowed. The left is severely narrowed. No spinal stenosis was noted.

On 3/06/2009 the carrier disputed treatment for degenerative disc disease, denying that the extent of injury included degenerative disc disease. The carrier accepted as compensable a sprain/strain to the lumbar spine.

The patient was seen by, M.D. on 3/12/2009 for a Designated Doctor Evaluation and for determination of extent of injury. Dr.'s evaluation included electromyography and nerve conduction studies, which disclosed no evidence of lumbosacral radiculopathy except for "slight nerve root irritation which does not need any further surgical interventions". The EMG showed increased insertional activity in the left L4-L5 paraspinous muscles, with otherwise normal findings. Dr. diagnosed low back pain secondary to L-S strain. The extent of injury included low back pain exacerbated with lumbosacral strain. Dr. noted that "prior records indicate that he does not want any injections or surgery, etc."

Peer Review was conducted by, M.D. on 6/16/2009. Dr. cited some records which were not available for me to review. Dr. mentioned that He was seen by, M.D. After the follow-up visit 2/17/2009 he was released to work without restrictions. Dr. recommended epidural steroid injections or referral to Dr. if no improvement. On 3/20/2009 Dr. again recommended epidural steroid injections and possible referral to Dr. for back surgery. He recommended continuing work without restrictions. Dr. noted that the patient reported previous history of work related low back injury in 2005 for which he was off work for a month.

On 08/18/2009 the patient was seen by, M.D. for neurosurgical consultation. There was no pain, weakness or numbness in the legs at the time of that evaluation. Examination revealed restriction of back flexion and extension with tightness of the lumbar paraspinous muscles groups. Neurological examination revealed intact deep tendon reflexes, negative straight leg raising, negative Patrick's and no Babinskis. Motor function and sensation were reported to be intact. MRI showed a mild HNP herniation at L4-L5 with degenerative disc disease at L2-L3, L3-L4, and L4-L5. HNP was worse on the right. Dr. diagnosed degenerative disc disease of L2-L5 with mild HNP at L4-L5. He felt that the patient may improve with epidural steroid injections and may benefit from IDD therapy.

X-rays of the lumbar spine 09/02/2009 were reported by, M.D. to show mild intervertebral disc space narrowing at L3-L4 and at L4-L5. The L5 segment is transitional. No acute findings or abnormal AP alignment noted. On 3/02/2010 a psychological reevaluation diagnostic interview was conducted at Rehabilitation, documenting some progress in response to the treatment program. The treatment to date was summarized, including documentation that he has been treated with six sessions of decompression therapy at the chiropractor's office which helped him feel his muscles looser, 16 physical therapy sessions, 3 injections administered in October 2009 (one a week over a period of three weeks), and prescription medication.

On 4/28/2010 a functional capacity evaluation was performed, wherein he was unable to perform at the PDL required for his usual job as a carpenter. On the fifth page of the history section of that document the patient was reported to have denied any prior lumbar injury or problems "as regards this injury of record".

On 5/6/2010, preauthorization was requested for a chronic pain management program. The requested treatment program was non-authorized 5/11/2010. The reviewer noted that the physical examination was very limited and that some signatures were missing, as was documentation of surgical consultation and comments about other types of physical intervention.

In a Request for Reconsideration submitted 5/24/2010 by, Ph. D. the following affirmations are made:

- Multiple providers reviewed this case.
- A comprehensive physical evaluation has been performed: a Functional Capacity Evaluation (FCE) was included with this request and contained a detailed physical examination history.
- Additionally, the request included the Industrial Rehabilitation Comprehensive Care Plan performed by Dr., along with
- A physical examination performed by Dr., which provided medical clearance.
- The patient has chronic pain syndrome as diagnosed by a psychologist with evidence of loss of function that has persisted beyond 3 months due to ongoing post injection complaints. This patient feels dependent on his health care provider, requires constant assistance from family members regarding ADL's. Due to his lack of work since his injury he has developed de-conditioning due to diffuse and fear avoidance of physical activities due to pain resulting in withdrawal from normal activities, to include work, recreations and social contacts. Although patient completed secondary level of care he has not been able to restore pre-injury function which prevents a safe return to work. Patient has developed anxiety, depression and sleep dysfunction as is evident in the above mentioned psychological diagnostic interview.
- Physical medicine, physical therapy, injections, and prescription medication have been unsuccessful in managing his chronic pain.
- A multi disciplinary and inter disciplinary test has been conducted which includes the last evaluation by the treating doctor that rules out conditions prior to entrance into the program, psychological diagnostic interview which includes vocational assessment and goals. All diagnostic procedures to rule out treatment pathology [have] been exhausted including MRIs.
- Client is not a surgical candidate
- Treatment plan has been attached with this request which specifies treatments with identified problems and outcomes that will follow.
- Vocational Assessment note is included with this request which discusses predictors of success and failure. Patient has a favorable outcome for his future and is wanting to pursue employment as a carpenter

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

First, the patient has not had the opportunity to participate in a structured chronic pain management program. According to the ODG Integrated Treatment-Disability Duration

Guidelines for Pain (Chronic). In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the “pain” and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the “sickness” role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors.

Second: He meets the criteria for a chronic pain management program.

According to the ODG Guidelines Criteria for the general use of multidisciplinary pain management programs (updated 7/27/2010): Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: [Some additional statements, listed within brackets, are derived from the medical records reviewed]

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: [this was demonstrated on the FCE].
    (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: [Patient currently does not meet employer’s physical demand requirements for his usual occupation].
    (e) Development of psychosocial sequelae that limit 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) [Evidence of this is seen on the FCE].
    (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: [Patient currently uses narcotic pain medication as prescribed].
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: [There are no additional treatment procedures pending. He declined further ESI injections.
3. An adequate and thorough multidisciplinary evaluation has been made… [This has occurred over the past 18 months, but no recent clinical notes from Dr. Syed were submitted for this review].
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.
8. Negative predictors of success … should be identified, and if present, the pre-program goals should indicate how these will be addressed. [Although the patient's job is no longer available, he has not had a negative relationship with employer].
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. [Request is for two weeks (10 days)].
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). 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).
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.

Third: Current treatment guidelines advocate the use of multidisciplinary measures for management of chronic pain

According to the Practice Guidelines for Chronic Pain Management, an Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society Regional Anesthesia and Pain Medicine: Anesthesiology 2010:112:1-1 (April, 2010):

Multimodal interventions should be part of a treatment strategy for patients with chronic pain. The task force recognizes that a patient's pain and health status may change over time, necessitating re-evaluations and changing treatment. Therefore, a long-term approach that includes periodic follow-up evaluations should be developed and implemented as part of the overall treatment strategy. The goal of treatment should be to effectively reduce pain while improving function and reducing psychosocial suffering when available, multidisciplinary programs may be used….Physical or restorative therapy may be used as part of a multimodal strategy for patients with low back pain and may be considered for other chronic pain conditions.

Consultants, American Society of Anesthesiology members, and ASRA (American Society of Regional Anesthesia) members also agreed that supportive psychotherapy, group therapy, or counseling should be performed for patients with chronic pain.

Supportive psychotherapy, group therapy, or counseling: these interventions may be considered as part of a multimodal strategy for chronic pain management.

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 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)**