COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 8/16/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Determine the appropriateness of the previously denied request for 10 sessions – Chronic Pain Management Program (CPMP).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Texas licensed clinical psychologist.

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

x Upheld (Agree)
□ Overturned (Disagree)
□ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for 10 sessions – CPMP.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 8/3/10.
- Company Request for IRO dated 8/2/10.
- Request for a Review by an independent Review Organization dated 7/28/10.
- Request for Medical Dispute Resolution dated 8/5/10.
- TDI Letter dated 8/2/10.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 8/2/10.
- Request Form dated 7/23/10.
- Request for Reconsideration dated 7/23/10.
- Adverse Determination After Reconsideration Notice dated 7/16/10.
- Patient Information/Insurance Information dated 7/14/10.
- Work Status Report dated 7/13/10, 5/20/10, 4/13/10
- Musculoskeletal Exam dated 7/13/10, 6/16/10, 5/20/10, 4/13/10
- Extremity Examination dated 7/13/10, 6/16/10, 5/20/10, 4/13/10

- Request for Services dated 7/12/10, 4/20/10.
- Request for Evaluation dated 6/23/10.
- Request Form dated 6/16/10.
- Request for Chronic Pain Management Program dated 6/16/10.
- Texas Worker's Compensation Work Status Report dated 6/16/10.
- Progress Report dated 6/16/10.
- Physical Performance Evaluation dated 3/29/10.
- Peer Review dated 3/13/10.
- Notice of Disputed Issue and Refusal to Pay Benefits dated 3/24/10.
- Indication for Evaluation (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):
Age:
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Lifting a heavy box.
Diagnosis: Thoracic sprain/strain and disc displacement, lumbar region strain/sprain, lumbar radiculitis, and myospasms.

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

This male sustained an injury on xx/xx/xx. According to the medical record, the mechanism of injury was lifting a heavy box. His diagnoses were thoracic sprain/strain and disc displacement, lumbar region strain/sprain, lumbar radiculitis, and myospasms. He completed extensive physical therapy and medical treatment and was placed at maximum medical improvement (MMI) in October of 2002. There was a significant gap in treatment between the claimant's MMI date and March of 2010, when he apparently started treating with Dr.. There was no explanation of this gap in any of the submitted medical records. He was referred for a psychological assessment to see if he would be appropriate for a CPMP. This reviewer is in agreement with similar concerns from both past reviews that a complete psychological assessment was not accomplished. This reviewer has given this feedback to this clinic concerning the prior reviews. It appeared, from medical records, that the claimant did have some psychotherapy that was deemed ineffective. However, there were no records of the notes concerning the psychotherapy and there was no psychiatric diagnosis in the available medical records. The original injury date was over two years old, the ODG is clear that 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.

The Official Disability Guidelines (ODG), Treatment Index, 8th edition (web), 2010, Pain – Chronic Pain Programs (functional restoration programs) states these programs are, "Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and

sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below:
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 addict.”

Dr., chiropractor, provided the initial review for this service request. According to his report, he stated that he spoke to the requesting provider, DC on 12/31/10 and based on their discussion and the clinical information available for his review, he found that the request did not meet preliminary guidelines and is not supported by medical necessity. Dr. stated, in his report, that the two lumbar spine MRI films that he reviewed reflected no significant findings and the claimant was at MMI. Dr. went on to report that, “There is absolutely no way to relate claimant's current subjective complaints with sprain/strain of x/x/xx." On a D.C. exam dated 4/13/10, the medical records indicated that there was a mildly decreased LROM with pain. The medical records also stated that on 4/20/10, a master’s level mental health professional (, MA) reported that the claimant still had high fear problems, and poor coping skills. She reported that the “claimant alleges so much pain, difficult time structuring life, remaining positive, being motivated to perform necessary actions for a successful recovery.” The medical records indicated that the claimant had made some improvement, according to Ms., as she noted a decrease in pain intensity levels, Beck Depression Inventory (BDI) scores, and Beck Anxiety Inventory (BAI) scores. There was also a discrepancy noted in the medial record of the examining chiropractor finding left straight leg raise (SLR) and a neurologist finding a right SLR. The reviewer noted that the discrepancy remained unexplained. The reviewer’s note indicated that the requesting provider was concerned about the claimant’s recent unexplained weight loss and that the claimant’s current physical status was largely unknown. While the claimant did have access to work, there was no light duty available. The medical record also indicated that there was a possibility that the chronic lower extremity problem may be due to an infection, which will also be investigated. Dr. stated that given the above, that all CPMP criteria did not appear to be met.

Neuro-psychologist, Dr., performed the appeal review. According to the medical record, Dr. was able to speak to Dr. (chiropractor) about the case. Dr. noted some similar concerns as the initial review, but also indicated a significant gap in treatment that Dr. said he was unaware of and would do some investigating. Dr. also mentioned to Dr. that a peer review report completed by Dr., on 3/13/10, discouraged further treatment and indicated that it was the peer reviewer's opinion that no additional clinical treatment was necessary. Dr. reported to Dr. that he was also unaware of this review. Dr. stated that there was insufficient

clinical information provided to establish the clinical necessity of a tertiary care CPMP in an interdisciplinary setting at this time.
There were significant gaps in the record and previous rehabilitation outcomes were not provided. Psychological testing had not been completed as required by the ODG. The requesting program is not CARF certified and does not have published clinical outcomes as required by the ODG. An LPC completed the behavioral health examination. There was no indication that this individual was supervised. This reviewer was unable to identify evidence of medical clearance or a plan for narcotic titration/tapering. There was no evidence that a medical director medically supervises the treatment provided. According to medical record, Dr. stated that these issues along with other deficiencies suggest that a CPMP program at this facility was not clinically supported. Suggestions were made to Dr. regarding these issues, according to the medical records.

Given the information received in the medical records, the two past reviews, and the ODG criteria, this reviewer is agreeing with the past reviews and the adverse determination is upheld.

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

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
x ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 8th edition (web), 2010, Pain – Chronic Pain Programs (Functional Restoration Programs).

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).