

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** JULY 22, 2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed chronic pain management program 5 X wk X 2 wks (97799)

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

**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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.2, 722.1, 724.4, 847.0	97799		Prosp	10					Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 161 pages of records received from to include but not limited to: TDI letter 7.2.10; preauth report 5.28.10; email from to dated 6.25.10; DWC form 1 3.5.10; ISD report of Injury; MRI C-Spine 4.3.09, 1.12.10; MRI L spine 4.3.09, 1.12.10; Imaging report 6.16.09; report 6.20.09; Memorial Hospital notes 6.25.09-7.29.09; FCE 5.18.10; PPE 6.25.10; BTE report 11.19.09; Dr. report 6.3.10; letter 5.12.09; Treatment clinic 6.8.09-5.17.10; notes 5.27.09-6.23.09; Dr. records 5.12.09-5.24.10; DWC form 73; forms; Physical Medicine and Rehabilitation Associates of notes 3.26.09-4.29.09; progress note 2.27.09, LPW; notes 2.27.09-3.19.09; X-ray L spine

Respondent records- a total of 114 pages of records received from to include but not limited to: TDI letter 6.2.10; request for an IRO forms; Preauth determination letters 5.28.10, 6.22.10; notes 5.26.10-6.22.10; Treatment clinic letter of medical necessity; FCE 5.18.10; PPE 6.25.10; BTE report 11.19.09; Memorial Hospital notes 6.25.09-7.29.09

Requestor records- a total of 47 pages of records received to include but not limited to:

notes 5.26.10-7.7.10; Treatment clinic letter of medical necessity; FCE 5.18.10; PPE 6.25.10; BTE report 11.19.09; Memorial Hospital notes 6.25.09-7.29.09

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained a work-related injury on xx/xx/xx while working. Patient was performing his usual job duties when he injured his back attempting to lift a computer off the floor. Records indicate he felt immediate pain in the low back and neck when he attempted this lift, and became immobilized, unable to straighten up for a period of time. The patient was treated by a company doctor originally, and is currently under the care of Dr.. He is s/p lumbar spine surgery, and continues with pain. He has not returned to work. Over the course of his injury, patient has been treated with the following modalities/diagnostics: x-rays, MRI's, physical therapy, chiropractic, pain injections, TENs unit, surgery x1 (July 2009), work conditioning (date unknown) and medications. Current medications are Hydrocodone and Valium, prescribed by Dr., his surgeon.

Patient was evaluated by on 5/26/10, where they found the following: increased crying episodes, feelings of hopelessness and helplessness, feelings of frustration, irritability, sadness, boredom, nervousness, and restlessness, anhedonia, short temper, etc. FCE places the patient at a Medium PDL and job requires a Heavy PDL. Current complaints also include average pain rated as 8/10. Bending and sitting too long increase the pain. Rest, medication, and physical therapy decrease the pain. BDI was a 38 and BAI was an 18. SOAPP was 0. Mental status exam reveals depressed mood and affect in a patient with good insight and judgment. He was diagnosed with pain disorder and mixed adjustment disorder and recommended for a twenty day chronic pain management program. The goals to be achieved are: encourage change of focus, decrease pain, improve functioning, decrease dependence on healthcare system and medications, improve mobility, decrease emotional distress, improve sleep duration, address self-defeating thoughts, increase perception of level of functioning, and address isolation and hostility.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

Patient has continued pain complaints, and has received evaluation from Healthtrust accompanied by a Letter of Medical Necessity from the treating doctor. FCE shows patient has improved to the Medium PDL, and RTW PDL is Heavy. Although patient may indeed be a candidate for a CPM program, the records provided do not meet medical necessity. A thorough evaluation has not been conducted, as per ODG. There is no multi-system current medical evaluation available, and no information regarding whether or not patient responded to his work conditioning program. Additionally, there is no explanation of why patient is diagnosed with adjustment disorder when BDI is in the severe range. Likewise, there is no explanation regarding if patient was referred for a psychotropic med evaluation. There is no specific titration schedule available for review that shows the MD has approved of and discussed this course of treatment with the patient. Records do not indicate that the stepped-care approach to therapy has been followed, with patient participating in lower level of IPT. As such, medical necessity cannot be established at this time

ODG recommends CPMP for this type of patient, and ODG supports using the BDI and BAI, among other tests, to establish baselines for treatment. [Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 2001.](#)

#### **See also:**

**Psychological treatment 2010 Pain Chapter:** Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment

incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:

**Step 1:** Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.

**Step 2:** Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

**Step 3:** Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines](#) for low back problems. ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

#### **Criteria for the general use of multidisciplinary pain management programs 2010 Pain Chapter:**

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 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](#)

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. (WCRI, 2005) (Joling, 2006) (PERI, 2005) (Smith, 2001) (Stover, 2007) Delayed recovery has been associated with delayed referral to nurse case management. (Pransky, 2006)

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES