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Notice of Independent Review Decision

DATE OF REVIEW: 12/31/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic pain management program. Ten day initial trial as outpatient.
Left hand and fingers

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Designated Doctor Evaluation report 02/19/09, M.D.
2. Initial behavioral health consultation 07/16/09 MA, MED, LPC.
3. Surgical evaluation 07/21/09, M.D.
4. Report of medical evaluation 09/18/09, D.C.
5. History and physical 10/22/09, D.O.
6. Physical Performance Evaluation 10/22/09, D.C.
7. Request for ten initial days of a chronic pain management program 11/03/09 MS, CRC, LPC.
8. Notice of denial of preauthorization 11/05/09 M.D.
9. Reconsideration for CPMP 11/24/09.
10. Notice of reconsideration 12/01/09, D.O.
11. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female whose date of injury is xx/xx/xx. Records indicate that the employee was scanning small packages on a conveyor belt which lacked side protection, her hand became caught at the end of the conveyor belt resulting in a crushing injury. The employee underwent surgical treatment with ventral skin grafting. Records indicate the employee has done well following surgery except for residual pain.

She was released to return to work with restrictions, and returned to work in February, 2009.

The employee underwent initial behavioral health consultation on 07/16/09 and was recommended to undergo individual psychotherapy with biofeedback training and referral for psychotropic medication evaluation.

An evaluation by Dr. on 10/22/09 noted the employee had not been on any medications for her pain complaints, and he started the employee on Lyrica.

Records indicate that physical therapy evaluation on 10/22/09 revealed the employee was currently at a light physical demand level and her job requires heavy.

A preauthorization review by Dr. on 11/05/09 recommended non-certification of interdisciplinary pain management for ten days. Dr. noted that he successfully completed a peer-to-peer discussion with Dr.. The employee was noted to have suffered a crush injury to her left upper extremity which is her dominant extremity. She suffered injuries to her second, third, and fourth fingers and required initial surgery with skin grafting. The most recent evaluation showed she still had decreased range of motion of the index and middle finger of the left hand as well as decreased ability to make a full fist. The employee had decreased grip strength and some sensory abnormalities that were not detailed. The employee was evaluated by Dr. who did not provide a detailed examination of the left upper extremity but did note she may have a component of complex regional pain syndrome, but this was never followed up. The employee was also noted to have evidence of persistent pain of the left shoulder but had never undergone an evaluation with regard to the left shoulder. With regard to psychological processes, Dr. noted the employee had evidence of posttraumatic stress disorder and had responded well so far to individual psychotherapy, and most likely would benefit from additional individual psychotherapy. With regard to interdisciplinary pain program, Dr. noted the employee had not received an adequate evaluation with regard to her left upper extremity and persistent pain generators. He noted the employee may have persistent pain generators in the left shoulder which needed to be evaluated and also may have evidence of complex regional pain syndrome which may require sympathetic blockade. He noted that an interdisciplinary pain management program was premature at that time and recommended non-certification.

A reconsideration request was reviewed on 12/01/09 by Dr. who recommended non-certification on reconsideration of chronic pain management program ten day initial trial. Dr. noted that the employee sustained a left hand crush injury with multiple lacerations and required debridement, full thickness skin grafts for the index, long, and ring fingers performed on 01/05/09.

The employee was noted to have done well postsurgically except for digital pain. She had been approved to return to light duty work. Dr. noted that the records reflect the employee had regained much of her functionality. She continued to have weakness in the hand secondary to injuries, and continued to have some restricted mobility. Dr. completed a teleconference with Dr. who indicated the diagnosis of complex regional pain syndrome had been ruled out, and that the employee did not require any sympathetic block. Dr. indicated he felt the employee was functioning at a light physical

demand level. The employee was noted to be taking very little medication at that time. Dr. noted there was no indication of failed work hardening or work conditioning and the employee had a good response to physical therapy. Dr. noted the employee had no psychological dysfunction and recommended non-certification of interdisciplinary pain management program as not medically reasonable or necessary.

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

The proposed chronic pain management program, ten day initial trial for left hand and fingers is not supported as medically necessary based on the **Official Disability Guidelines**. The employee sustained a crush injury to the left hand requiring two surgical interventions with full thickness skin grafts. The employee is noted to have improved in response to physical therapy as well as individual psychotherapy and biofeedback training. She has returned to work with restrictions. Records indicate the employee is not a surgical candidate and CRPS has been ruled out. Noting that the employee has returned to work, there is no medical necessity for chronic pain management program.

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

The 2009 **Official Disability Guidelines**, 15th Edition, The Work Loss Data Institute. Online edition. Pain Chapter

Criteria for the general use of multidisciplinary pain management programs:

(1) Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

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](#).