

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 06/09/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: APPEAL Chronic Pain Management program 5xWk x0
2Wks-lumbar spine 97799

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

Texas Licensed Psychologist

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. Clinical note dated 06/22/09, , MD
2. Clinical notes dated 07/07/09 and 08/05/09, , MD
3. Procedure note dated 07/22/09, , MD
4. Clinical note dated 09/24/09, , MD
5. MRI of the lumbar spine dated 06/02/09, , MD
6. Operative note dated 10/28/09, , MD
7. Physical therapy notes dated 03/26/10 and 04/07/10, , PT
8. Clinical notes dated 03/31/10 and 04/14/10, , DO
9. Functional capacity evaluation dated 03/31/10, , OTR
10. Clinical note dated 04/16/10, , DO
11. Behavioral mental health evaluation dated 04/15/10, , LPC, PhD
12. Prior review dated 04/22/10, Dr.
13. Prior review dated 05/13/10, Dr.
14. Coversheet and working documents
15. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who was injured on xx/xx/xx, while unloading a truck. The employee was seen by Dr. on 06/22/09 and complained of 8/10 pain. The employee was reported to have completed a short course of physical therapy with no significant improvement. The employee underwent a lumbar epidural steroid injection on 07/22/09 at the L5-S1 level.

An MRI of the lumbar spine dated 06/02/09 revealed a 4 mm central protrusion, contacting the S1 nerve root at the L5-S1 level.

The employee underwent a lumbar microdiscectomy and laminectomy at the right L5-S1 on 10/28/09.

The employee was noted to have a light physical demand level on a Functional Capacity Evaluation dated 03/31/10. The employee was noted to require up to 75 pounds of lifting for occupational physical demand level.

A therapy note dated 04/07/10 reported the employee had completed 13 out of 18 pre-authorized sessions.

A psychological evaluation performed on 04/15/10 by LPC Guadalupe Escamilla reported the employee had a Beck Depression Inventory score of 27, Beck Anxiety Inventory score of 26, fear-avoidance beliefs questionnaire score of 27 on the work scale, and 13 on the physical activity scale. The employee was noted to have previously undergone physical therapy, therapeutic exercises, epidural steroid injections, and surgery previously along with medication management. The note reported the employee was taking Hydrocodone 5/500 every five hours. The employee was administered the MMPI-2 with mild elevations on scales measuring somatic concerns. The employee was recommended for a chronic pain management program.

A prior review by Dr. on 04/22/10 did not recommend a chronic pain management program secondary to not participating in individual psychotherapy.

A prior review by Dr. on 05/13/10 did not recommend a chronic pain management program as medically necessary secondary to no prior treatment with individual psychotherapy or psychotropic medications.

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

The request for a chronic pain management program five times a week for ten weeks is not medically necessary. The clinical documentation indicates the employee underwent lumbar spine surgery on 10/28/09. The employee also completed 13-18 postoperative sessions of physical therapy. The employee was noted to have a light physical demand level on functional capacity evaluation testing. The FCE reported the employee did not meet occupational standards. Two prior reviews did not recommend participation in a chronic pain management program secondary to the employee not participating in a brief course of individual psychotherapy or being treated with psychotropic medications. There was no clinical documentation submitted after the prior reviews to dispute the findings of no prior psychological treatment. Practice guidelines recommend that employees be unresponsive to prior treatment and there be an absence of other treatments likely to result in significant clinical improvement before participation on a multidisciplinary pain management program would be warranted. In consideration of the records and facts presented, there is no supportive evidence to recommend overturning the prior denials. As such, the request for a chronic pain management program five times a week for ten weeks is not recommended as medically necessary at this time.

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

Official Disability Guidelines, Pain Chapter, Online Version

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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(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).