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Notice of Independent Review Decision

DATE OF REVIEW: 02/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional 10 sessions Chronic Pain Management Program

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

Certified by the Texas State Board of Examiners of Psychologists

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	307.89	97799	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Peer Review Report dated 6/18/09

Physicians'/practitioners' notes from 5/1/09 through 1/26/10

Performance Evaluation dated 9/22/09, 5/6/09

Chronic Pain Management Program notes from 8/13/09 through 12/15/09

X-rays reports dated 6/3/05, 8/14/05

Official Disability Guidelines cited – Pain Chapter Criteria for the general use of multidisciplinary pain management program

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PATIENT CLINICAL HISTORY:

According to the information provided, this claimant injured on xx/xx/xx was working as a xxxx carrying a 100-pound barrel of used oil when he slipped on a puddle of oil. The earliest clinical record submitted for review is a diagnostic interview and treatment plan dated 05/01/06. Treatment to date includes diagnostic testing, chiropractic adjustments and epidural steroid injection x 3. The patient was recommended for psychological clearance for a spinal cord stimulator trial and then a work hardening program. At that time BDI was 38 and BAI was reportedly in the moderate range for anxiety. Diagnoses are listed as major depressive affective disorder, recurrent episode, severe degree without psychotic behavior; panic disorder without agoraphobia; and generalized anxiety disorder. The patient was recommended as a good candidate for a spinal cord stimulator.

The next available record is a psychological evaluation dated 05/06/09 to determine the patient's appropriateness for a chronic pain management program. Treatment to date includes diagnostic testing, spinal cord stimulator implant in 2008, chiropractic adjustments, and 8-9 ESIs in 2005-2006. The patient has a history of previous L4-5 and L5-S1 lumbar fusion. Medications are listed as Ibuprofen, Soma and Norco. The patient reports difficulty sleeping, fatigue, sense of failure, worry, confusion and guilt. BDI is 23 and BAI is 13. Diagnoses are chronic pain disorder, associated with both psychological features and a general medical condition, and depressive disorder. The patient underwent a physical performance evaluation on 05/06/09. The patient subsequently underwent 6 sessions of individual psychotherapy. Progress note dated 09/15/09 indicates the patient's BDI is 45 and BAI is 38.

The patient underwent a physical performance evaluation on 09/22/09. BDI is reported as 53 and BAI is 39. Examination findings dated 11/13/09 indicates that the patient is starting a chronic pain management program and has been recommended for antidepressant medication; however, the patient reports that Cymbalta made him angry, and Zoloft and Lexapro made him feel weird. The patient reportedly had multiple lumbar spine surgeries starting in 1995. Current medications are listed as Ibuprofen, Paxil, Norco, and Soma. The patient underwent 10 days of a chronic pain management program. Progress notes indicate BDI increased from 53 to 58 and BAI improved from 39 to 24. Carry ability increased from 30 to 40 lbs, floor to knuckle from 10 to 30 lbs, knuckle to shoulder 30 to 45 lbs., and shoulder to overhead from 30 to 35 lbs. Sitting, standing and walking endurance improved. The patient's medication usage is unchanged: Norco 10/325 mg 1 pill every 6 hrs, Soma 350 mg 1 pill every 6 hrs, Ibuprofen 600 mg 1 pill every 6 hrs, and Paxil 20 mg 1 pill daily.

A request for 10 additional sessions was non-certified on 12/09/09. According to the reviewer, the patient has been treated with overuse of opiates and very passive coping strategies with mild to moderate psychological issues on May evaluation. A letter of appeal dated 12/24/09 indicates that the patient has made steady gains in lifting, endurance, and sitting tolerance. The patient has signed a medication contract and is willing to reduce medication use and adhere to

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random drug screens. The patient continues to display moderate pain behaviors during activity, and has been working with the vocational specialist. A subsequent review dated 01/06/10 again non-certified the request for 10 additional sessions of chronic pain management. Examination findings dated 01/26/10 indicates that the patient is without improvement since his last visit. The patient's urine drug screen collected on 12/12/09 had multiple inconsistencies: positive for carboxy-THC, negative for Carisoprodol, and negative for opiates, even though the patient is prescribed Hydrocodone and Soma. The patient was given a verbal warning that he has violated the medication contract, and that repeated violation may cause him to be discharged from care.

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

In the Reviewer's opinion, the evidence submitted did not meet ODG criteria for medical necessity at an outpatient pain rehabilitation program. The Reviewer commented that the CPMP appears to have yielded little improvement in functionality and little modification of opiate use. In addition, the documentation does not provide rationale for CPMP beyond the 10 days already provided. Finally, the Reviewer noted the documentation does not show motivational evidence on the part of the patient to adhere to the medication contract (7). Given the documentation of a violated medication contract and a verbal warning, the Reviewer recommended additional attention should be given to the most appropriate treatment approach (pain program vs. substance abuse) and the possibility of incorporating addiction consultation into the pain program for this patient.

According to the Reviewer, it is doubtful that at this point, post injury in 2005, another 10 days in CPMP would benefit the patient (1). Therefore, the denial of request for an additional 10 days in CPMP is upheld.

Reference: ODG Pain Chapter

General use of multidisciplinary pain management programs	<u>Outpatient</u> 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
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will</p>
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	<p>be followed.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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).</p> <p>(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</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> 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 <u>Chronic pain programs, opioids; Functional restoration programs</u>.</p>
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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)

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