

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 02/19/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic Pain Management Program x 10 sessions at 8 hours a day

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

Texas Board Certified Physical Medicine & Rehabilitation and Pain Management

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. IRO referral forms.
2. Work capacity evaluation 12/03/09.
3. Mental health evaluation, MED, LPC, 12/15/09.
4. Pre authorization request, M.D. 12/18/09.
5. Pre authorization determination, M.D. 12/26/09.
6. Adverse determination letter 12/28/09 regarding non authorization chronic pain program.
7. Request for pre authorization, concurrent review and voluntary certification form 01/04/10 regarding chronic pain management x10 sessions.
8. Request for reconsideration, M.D. 01/04/10.
9. Preauthorization determination 01/11/10, M.D.
10. Adverse determination letter 01/11/10 regarding non authorization chronic pain program.
11. Independent medical evaluation report Dr. M.D. 01/13/10.
12. Appeal letter M.D. 02/01/10.
13. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is xx/xx/xx. Records indicate the employee was injured secondary to motor vehicle accident. He is status post ACDF C4-5, C5-6 performed on 10/04/05, and arthroscopic rotator cuff repair performed 07/18/08.

A Work Capacity Evaluation (FCE) dated 12/03/09 noted that the employee is currently performing at a light physical demand level. His job as a police officer requires medium-heavy physical demand level.

A mental health evaluation by, ED, LPC performed 12/15/09 reported the employee to fall within mild range for depression and moderate range for anxiety. Ms. concluded that the employee is an appropriate candidate for a comprehensive chronic pain management program that would include individual psychotherapy, group psychotherapy, biofeedback, vocational counseling, nutritional counseling, exercise, and physical therapy.

A preauthorization request from, M.D. dated 12/18/09 noted the employee was recommended to undergo chronic pain management program to address the psychological component of his injury.

A preauthorization review by, M.D. dated 12/26/09 determined that the medical records submitted for review did not support medical necessity of 10 sessions of chronic pain management. Dr. noted there is no medical indication for pain management at this point and time, as the employee has no plans to return to work and there is no evidence that he will be weaned off his medications by the treating provider. If there were weaning plans, this could be done in the prescribing physician's office.

A reconsideration/appeal request was reviewed by, M.D. on 01/11/10. Dr. discussed the case with Dr. who confirmed that prescription medications were being provided by Dr. and that the referral for CPMP was from Dr. for the purpose of detox, but there were no drug screens available to actually determine if the employee is taking medications. Dr. also noted that UR records reflect a directive from a prior PA in 09/2009 to wean from Soma, and records from 12/2009 reflect the employee has continued to take Soma, contrary to ODG. Dr. further noted that as noted by prior reviewer, the employee has plans to apply for SII and has no plans to return to gainful employment. Dr. noted that symptoms survey of reported level of functioning was inconsistent with FCE performance. Self reported symptoms were noted to reflect that he would be an invalid which is not consistent with serial records. Dr. concluded that the request did not meet ODG criteria.

The employee underwent an Independent Medical Evaluation (IME) by Dr. on 01/13/10. Dr. noted that the employee currently averages 1 Hydrocodone APAP 10/650 mg daily, Tramadol 50 mg at bedtime, Piroxicam 20 mg daily, Sertraline 100 mg daily, and a rare Carisoprodol. Dr. noted this represents significant recent reduction in medication during which period the employee acknowledges feeling jittery initially. Dr. diagnostic opinion was the employee probably aggravated cervical spondylosis with minor features initially of cervical radiculopathy. The employee is now post C5-C7 fusion with residual symptoms. There is a lumbar spondylolysis with minor criteria for left L5 radiculopathy. The employee is status post second left shoulder surgery involving rotator cuff repair and subacromial decompression. The employee has mild residual atrophy of the left shoulder girdle and presently a positive Yergason test suggestive of bicipital tendinitis. Finally, Dr. opined the employee has a chronic pain syndrome with an entranced opinion of disability. Dr. noted that the employee would be capable of some work of at least sedentary level of up to four to five hours per day providing for flexibility to get

around every thirty minutes or so. Walking should be limited but should not exceed 200 yards per attempt. Squatting, stooping and lifting in excess of ten pounds should be prohibited. Driving should not exceed forty-five minutes per ride. The employee was noted to continue to take medication with potential for causing drowsiness, and should not do commercial driving or operative potentially hazardous equipment.

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

The clinical data submitted does not support a determination of medical necessity for a chronic pain program. The employee was injured in a motor vehicle accident on xx/xx/xx. The employee subsequently underwent ACDF at C4-5 and C5-6 performed on 10/04/05. The employee is also noted to have undergone left shoulder arthroscopic rotator cuff repair. In addition, the employee is noted to have been treated with physical therapy, medications, injections, aqua therapy and a brief course of individual psychotherapy. Work capacity evaluation dated 12/03/09 indicates that the employee was capable of performing at a light PDL, but there is some discrepancy in the documentation as to the employee's self reported levels of functioning, and the employee's work capabilities according to the IME doctor. The request for chronic pain program indicates that the program was addressed to address the psychological component of the injury. As noted by previous reviewers, weaning of medications can be done without a multi disciplinary pain management program. It is further noted in the records that the employee has no intentions of returning to work and is applying for SSI disability. It appears that the previous denials were appropriate and should be upheld on IRO.

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

Official Disability Guidelines Pain chapter

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.

(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](#).