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Notice of Independent Review Decision

DATE OF REVIEW: 5/7/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 10 sessions of Chronic Pain Management.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of 10 sessions of Chronic Pain Management.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: Request for MDR – 4/22/10, Initial Interview – 3/25/10; Center Notes – 8/27/09-3/12/10, History – 8/15/08; Diagnostics CMT/ROM report – 8/15/08 & 5/22/09; and Medical Center Operative Report – 10/27/08.

Records reviewed from Insurance: Denial Letters – 4/5/10 & 4/13/10; IRO request – 4/16/10, Reconsideration request – 4/6/10, Pre-auth Intake Form – 3/29/10; and MD letter – 1/20/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was involved in a work-related injury sustaining a torn ligament to left ankle after stepping wrong. A spinal column stimulator was placed in 2002. According to available records the patient was seen for follow-up and continuing care at the Center in until 2004 but had to stop going to that clinic. Although the patient was referred to a physician, insurance approval was not given.

The patient saw Dr. at the Center in for evaluation and treatment. He informed Dr. that the spinal cord stimulator was no longer working. He stated that he had not had any pain management or physical therapy after the last visit (presumably in 2004). The patient complained of burning pain in the left ankle, increasing with weight-bearing and decreasing with oral pain medications. He was taking Ambien at night for sleep. Examination revealed ankle pain during movement and weight bearing. Dr. diagnosed complex regional pain syndrome to the left ankle, status post implantation of spinal column stimulator with exhausted internal pulse generator battery and displacement of electrodes. He proposed revision and replacement of the spinal column stimulator electrodes and the battery. He prescribed topical Voltaren gel and Lyrica 75 milligrams PO twice daily.

Computerized muscle testing and range of motion measurement was done 8/15/2008, demonstrating deficiency in strength and range of motion of the left tackle compared with the right.

On October 27, 2008 Dr. took the patient to surgery for revision of the spinal cord stimulator connection, replacement of the internal pulse generator battery, and for programming of the spinal cord stimulator.

Computerized muscle testing and range of motion measurement was done 5/22/2009, demonstrating deficiency in strength and range of motion of the left tackle compared with the right, except for the left ankle plantar flexion strength, which was greater than the right.

On 8/27/2009 Dr. reported that the patient was doing fairly well with the spinal column stimulator and oral pain medication.

On a follow-up visit 12/10/2009 the patient reported increased swelling in the left ankle, rating pain at 9/10 on the visual analogue scale. Dr. refilled the medications and recommended a soft ankle support wrap for the left ankle.

On 01/20/2010 Dr. submitted a letter To Whom It May Concern regarding the patient's medical diagnoses and medications. [p. 52].

On 3/12/2010 the pain level was 8/10 on the visual analogue scale. The patient was sleeping 3 to 4 hours per night with interruptions due to pain. Dr. diagnosed left ankle pain with complex regional pain syndrome and morbid obesity. He recommended continuation of the present care plan and medications. He encouraged weight loss and recommended bringing this shoe inserts at the time of the next visit.

As requested by Dr. the patient was seen 3/25/2010 for an initial interview by, MA, LPC, QMHP. A request was made for the patient to participate in 10 sessions of a behavioral multidisciplinary chronic pain management program. The examiner affirmed that the patient meets the criteria for the general use of multidisciplinary pain management program, according to the official disability guidelines. Ms. addressed specific criteria in the guidelines, affirming that the patient meets the specific criteria.

On 3/29/2010 a preauthorization request was submitted by LLC for chronic pain management program, 10 sessions/80 hours, at a frequency of five per week for two weeks, eight hours per day.

The requested services were non-certified 4/05/2010

On 4/6/2010 a request for reconsideration was requested.

On reconsideration the requested services were again non-certified 4/13/2010

On 4/22/2010 a request for medical dispute resolution was submitted by PhD., who again asserted than the patient had exhausted all lower levels of care and that he meets the criteria for the general use of a multidisciplinary pain management program according to the Chronic Pain chapter of the Official Disability Guidelines. Citing the Official Disability Guidelines Dr. affirmed that the patient qualifies for such a program based on all accepted clinical guidelines and practice standards.

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

First, the patient has not had the opportunity to participate in a structured chronic pain management program.

According to the ODG *Integrated Treatment/Disability Duration Guidelines for Pain (Chronic)*

In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the "sickness" role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors.

Second: The patient meets the criteria for a chronic pain management program.

According to the ODG Guidelines Procedure Summary pertaining to chronic pain management, Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances [the additional statements listed within brackets were derived from the medical records reviewed, including the document submitted by Dr.]:

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: [according to the submitted records and the summary submitted by Dr., the patient requires assistance from family members and friends, on a regular basis, for basic daily activities of living and continues to rely on the treating doctor as a primary means of pain relief].
- (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain: [this was demonstrated on the computerized muscle testing, range of motion measurements and functional assessment].
- (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts: [The patient has avoided engaging in any recreational or social activities].
- (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: [Patient currently does not meet employer's physical demand requirements as evidenced through attached functional assessment].
- (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): [Patient demonstrates a combination of symptoms of depression and anxiety, along with fears of functioning and problems with sleeping habits].
- (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component: [This guideline has been met].

(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: [Patient currently relies on narcotic pain medication as his primary means of pain relief! Moreover, according to the SOAPP assessment score, the patient demonstrated a negative risk for abuse of prescribed narcotic pain medications, reported in the Interview of 3/25/2010].

- Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement: [There are no additional treatment procedures pending].
- An adequate and thorough multidisciplinary evaluation has been made...: [This guideline has been met, as documented above].
- 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.
- 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.
- Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed: [A treatment plan was submitted in the clinical record dated 3/25/2010].
- 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. [These factors were discussed with the patient, and the patient agrees to proceed with the recommended treatment (refer to the document dated 3/25/2010 and the request submitted by Dr.)].
- Negative predictors of success ... should be identified, and if present, the pre-program goals should indicate how these will be addressed. [The patient does not have a negative relationship with employer...Patient enjoyed working and is anxious to return to the workforce. Patient seems motivated and is not discouraged about their future employment]. High levels of psychosocial distress. [This will be addressed in group behavioral sessions. No current financial disability disputes... Patient does not smoke]. Increased duration of pre-referral disability time. [This has been addressed. Patient does

not take any more medication than has been prescribed]. Elevated pre-treatment levels of pain. [Patient's level of pain will be addressed during group behavioral therapy].

- 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.
- Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. [Request is for two week (10 day) trial].
- 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. [According to Dr. This will be provided].
- 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). 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).
- 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). [According to Dr. the patient will be returned to the workforce at the completion of the program].
- 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.
- 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.

Third: Current treatment guidelines advocate the use of multidisciplinary measures for management of chronic pain

According to the Practice Guidelines for Chronic Pain Management, An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society Regional Anesthesia and Pain Medicine: Anesthesiology 2010:112:1-1 (April, 2010):

Multimodal interventions should be part of a treatment strategy for patients with chronic pain. The task force recognizes that a patient's pain and health status may change over time, necessitating re-evaluations and changing treatment. Therefore, a long-term approach that includes periodic follow-up evaluations should be developed and implemented as part of the overall treatment strategy. The goal of treatment should be to effectively reduce pain while improving function and reducing psychosocial suffering when available, multidisciplinary programs may be used....

Physical or restorative therapy may be used as part of a multimodal strategy for patients with low back pain and may be considered for other chronic pain conditions.

Consultants, American Society of Anesthesiology members, and ASRA (American Society of Regional Anesthesia) members also agreed that supportive psychotherapy, group therapy, or counseling should be performed for patients with chronic pain.

Supportive psychotherapy, group therapy, or counseling: these interventions may be considered as part of a multimodal strategy for chronic pain management.

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)**
Practice Guidelines for Chronic Pain Management, An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society Regional Anesthesia and Pain Medicine: Anesthesiology 2010:112:1-1 (April, 2010)
Consultants, American Society of Anesthesiology members, and ASRA (American Society of Regional Anesthesia)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**