DATE OF REVIEW: October 22, 2010

IRO Case #:

Description of the services in dispute:

This is a request for chronic pain management 5 times a week for 2 weeks.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The clinician who provided this review is a licensed Psychologist in two states. This reviewer is a diplomate in Clinical Neuropsychology, by the American Board of Professional Neuropsychology. This reviewer is a member of the American Psychological Association, the American Pain Society and the National Academy of Neuropsychology. The reviewer has served as the Chief of Neuropsychology and Rehabilitation Psychology at a university medical center, an assistant professor of Psychology, Director of a Children's Rehabilitation Program and staff Psychologist. The reviewer is currently in private practice where has nearly 30 years of experience.

Review Outcome

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

Upheld.

The medical necessity of an additional 10 sessions of chronic pain management program treatment following the completion of 10 sessions of chronic pain program management treatment is not established.

Information provided to the IRO for review

Records Received From State:

Request For a review by an Independent Review Organization, 7 pages, 10/6/10
Worker's Comp Services, Request for Reconsideration, 10/4/10, 4 pages
Worker's Comp Services, Notification of Determination, 9/24/10, 3 pages Records
Received from URA:

Notice of Assignment, 10/7/10, 1 page
Preauthorization Request, 9/27/10, 3 pages
Request for Reconsideration, 9/27/10, 2 pages
MD, Copy of Written Prescription, 9/22/10, 1 page
Request for Additional Sessions, 9/21/10, 2 pages
Progress Summary, 9/16/10, 6 pages
Treatment Plan, 1 page
MD, Progress Note 8/23/10, 1 page
Texas Worker's Compensation Work Status Report, 6/19/10, 1 page
Extremity Examination, 8/18/10, 1 page
Extremity Examination, 8/19/10, 1 page
Texas Worker's Compensation Work Status Report, 7/20/10, 1 page
Extremity Examination, 7/20/10, 2 pages
Texas Worker's Compensation Work Status Report, 6/23/10, 1 page
Extremity Examination, 8/25/10, 1 page
MD, Copy of Written Prescription, 9/3/09, 1 page
Extremity Examination, 6/23/10, 1 page

Patient clinical history [summary]

The focus of this review is an appeal for additional chronic pain management treatment 5 times a week for 2 weeks. A date of injury of xx/xx/xx was submitted. On this date, it is reported that the injured worker sustained injury when his left leg fell through the gap between the. He is status post left shoulder surgery on 10/12/09 and on 5/13/10. A
functional capacity evaluation (FCE) was submitted which provided evidence of reduced flexibility in the left shoulder, knee, and lumbar spine with associated pain. Bilateral decreases in strength were noted. The injured worker was admitted for the initial 10 sessions of chronic pain management program treatment and did display improvement. After 10 sessions, visceral analog score (VAS) scores reduced from 5/6 to 4 on a 10 point scale. Global assessment of functioning (GAF) score increased from 55 to 65. Requirements for pain medication were reduced. Beck's Depression Index (BDI) score on 9/16/10 was a 2 and Beck's Anxiety Index (BAI) score of 1 was noted. Based on the negligible evidence of ongoing anxiety and depression, an additional 10 sessions of chronic pain management treatment was denied. This finding was sustained on appeal/reconsideration with a finding that no significant psychological symptoms continued to be present after 10 sessions of chronic pain management program treatment.

A report completed by, MA, LPC (intern) was provided for review. This report provided evidence of negligible depression (BDI=3) and negligible anxiety (BAI=1). Apparently, the program does not utilize the services of a licensed clinical psychologist/pain psychologist.

Neuropsychological test results were provided for review.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

In review of the submitted documentation, the medical necessity of an additional 10 sessions of chronic pain management program treatment following the completion of 10 sessions of chronic pain program management treatment is not established. The original denial should be upheld.

The requesting program does not appear to be Commission on Accreditation of Rehab Facilities (CARF) certified. The services of a pain psychologist and the results of a formal psychological evaluation as required by ODG guidelines were not provided. Clinical information provided after the completion of 10 chronic pain management treatment sessions provided evidence of negligible anxiety and depression as measured by the self-report inventories administered. The injured worker reported that he was experiencing minimal psychosocial distress after completing 10 sessions of chronic pain management program (CPMP) treatment. Since a CPMP program is a multidisciplinary program, there seems to be little evidence that the injured worker requires the psychosocial components which are part of this program. It should also be noted that the required psychological test data providing evidence of objective psychological impairment required by ODG was not submitted and appears not to have been completed. It is also not known if the requesting program is CARF certified are known to have positive functional outcomes as required by TDI and recommended by ODG.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines in Workers' Compensation, Online Edition

Chapter: Pain

Chronic pain programs (functional restoration programs)

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary

care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) See Biopsychosocial model of chronic pain.

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) (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 - 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. 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.