

# CASEREVIEW

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## Notice of Independent Review Decision

**DATE OF REVIEW:** November 30, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management Program x 80 hours/units

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

07/27/11: Initial Rehab Evaluation at Injury Clinic by DC

07/27/11: Initial Behavioral Medicine Consultation at injury Clinic by, MS, LPC-S, CRC

08/10/11: Assessment/Evaluation for Chronic Pain Management Program at Injury Clinic by MS, LPC-S, CRC

08/10/11: Functional Capacity Evaluation by DC

08/14/11: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment at Injury Clinic by MD, PhD, and DC  
08/26/11: MRI of the lumbar spine interpreted by MD  
08/29/11: History and Physical Chronic Pain Management Program by MD  
08/30/11: Peer Review by MD with  
09/22/11: Psychological Testing Report at Injury Clinic by MS, LPC-Intern  
09/26/11: Follow-up evaluation with MD  
10/05/11: Chronic Pain Management Program Preauthorization Request by PhD  
10/10/11: UR performed by PhD  
10/17/11: Reconsideration: Request for 10 Days of a Chronic Pain Management Program by PhD  
11/04/11: UR performed by PhD

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx while pulling on some stock that was on the floor. It was reported that the work conditions were such that he had his right leg in external rotation while pulling towards himself when he began to have pain in his back and groin area. He had CT, MRI and X-rays and his treatment has included chiropractic manipulations, massage, and epidural steroid injections.

On July 27, 2011, the claimant had an initial rehab evaluation with DC for right lower back/sacroiliac pain and right anterior groin pain. On physical examination the claimant walked with a mild limp and had an antalgic stance. Strength was 5/5. Deep tendon reflexes were equal and reactive. Sensation was intact over the shins. Lumbar range of motion was moderately limited by pain, especially in flexion and extension. L3-L5 palpated tender in the midline. The right L5-S1 was very tender as was the right sacroiliac articulation. Dr. diagnosed lumbar sprain/strain, sprain/strain of the right pubo-femoral ligament of the right hip, and right sacroiliac sprain/strain. 12 sessions of physical rehabilitation was recommended at a frequency of 3 times per week for 4 weeks. A MRI of the lumbar spine and pelvis were also suggested.

On July 27, 2011, the claimant had an initial behavioral medicine consultation with MS, LCP-Intern and MS, CRC, LPC-S. Current medications were listed as Tramadol 50 mg and Motrin 800 mg. The claimant scored a 14 on the BDI-II, indicative of mild depression. He scored 13 on the BAI, indicative of mild anxiety. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) revealed significant fear avoidance of physical activity in general (FABQ-PA=16), as well as significant fear avoidance of work (FABQ-W=31). It was opined that the initial evaluation that was completed suggested that the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention for a minimum of 4 weeks.

On August 10, 2011, the claimant had an evaluation for chronic pain management program by MS, LCP-Intern and MS, CRC, LPC-S. Multiaxial Diagnosis: Axis I:

Pain disorder, associated with both psychological factors and a general medical condition, chronic. Axis II: No diagnosis. Axis III: Injury to back. Axis IV: Primary support group, economic occupational problems. Axis V: GAF: current 65. Estimated pre-injury GAF: 85+. The evaluator concurred with Dr. recommendation that the claimant participate in a chronic pain management program.

On August 10, 2011, the claimant underwent a Functional Capacity Evaluation performed by DC. Based on the test results the claimant was unable to meet his previously required demand level of medium. It was recommended that the claimant participate in a 10 day chronic pain management program to help achieve maximum functional improvement.

On August 26, 2011, an MRI of the lumbar spine revealed: 1. Multilevel changes of spondylosis. 2. Central canal narrowing most advanced at the L4-L5 level but is only mild in degree. 3. A small to medium sized, left far lateral L3-L4 disk herniation could be displacing the exiting left L3 nerve root.

On August 29, 2011, the claimant was evaluated by MD for a chief complaint of low back pain radiating into his right lower extremity. On physical examination he had decreased active and passive range of motion on flexion, extension and rotation of his lumbar spine due to discomfort in his lower back. He had some myospasms on the right side greater than the left. He had a positive right straight leg raise test with weakness on the right leg as well. He had subjective paresthesias extending to below the right knee. Diagnosis: Lumbar sprain/strain and lumbar herniated disc at L3-4. Dr. opined the claimant would be an excellent candidate for the chronic pain management program. A psych intake evaluation update was also requested in accordance with chronic pain management regulations.

On August 30, 2011, a peer review was completed by MD who rendered the following opinions: 1. No, the claimant's current symptoms are not the result of the alleged on the job injury on xx/xx/xx. First, it must be noted that the patient's statements regarding the initial injury were so variable and changing, that it is not completely clinically credible that an injury actually occurred on xx/xx/xx. That said, please note that the reports surrounding the original injury pertained to left sided symptoms. In 2011, symptoms were described as right sided throughout the records. The records describe different locations; therefore, it is unlikely that they were the same injury. Also, the original injury from xx/xx/xx allegedly was a lumbar strain. Under ICD 847.2, in the ODG studies on disability duration for lumbar sprain strain injuries, note: At most, 35 days could be credibly ascribed as being disability related to the original injury. 2. Under ODG, an independent home program and over the counter NSAID medicine would be all that would be needed for the original alleged xx/xx/xx back strain injury.

On September 22, 2011, the claimant underwent psychological testing by MS, LPC-Intern and PsyD. The claimant scored 11 on the BDI-II, indicative of mild

depression. He scored 7 on the BAI, indicative of mild anxiety. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) revealed significant fear avoidance of physical activity in general (FABQ-PA=16), as well as significant fear avoidance of work (FABQ-W=31). His OSWESTRY disability score was 26%. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psych factors and a general medical condition, chronic. Axis II: No diagnosis. Axis III: Injury to back. Axis IV: Primary support group, Economic problems and Occupational problems. Axis V: GAF=60 (current). Estimated pre-injury GAF=85+. Dr. concurred with Dr. recommendation that the claimant participate in the chronic pain management program.

On September 26, 2011, the claimant had a follow-up evaluation with , MD who noted he did have an EMG done, but no report at that time to review. Dr. refilled his Tramadol 50 mg and Motrin 800 mg.

On October 5, 2011, a Chronic Pain Management Program Pre-Authorization Request was complete by PhD. Dr. spelled out the claimant's qualifications according to the ODG criteria as follows. 1(a) Mr. has noted dependence/reliance on family members for basic ADLs such as cleaning and yard work; these were activities he easily completed prior to the work injury. 1(b) He has obvious secondary physical deconditioning, evidenced by his inability to perform at his required PDL of Heavy. He is currently assessed as being capable of a Light PDL. 1(c) Mr. reports that, since the injury, he has avoided participation in family and social activities. 1(d) Much like criterion (c), he has failed to restore his pre-injury level of function at this point, evidenced by the PPE, and has not returned to work and indicated non-involvement in recreational activities. 1(e) Mr. has endorsed mild depression (BDI-II score of 18). He reports fear-avoidance of activities at home and at work [FABQ-PA score of 15, FABQ-W 30; his Oswestry score is in the moderate range (26%)]. 1(f) Mr. has not been diagnosed with a personality disorder or psychological condition without a physical component. 1(g) Mr. continues to take Ibuprofen 800 mg and Tramadol 50 mg, and despite this, endorses a pain level of 8/10, depending on his level of activity. 2 Mr. has not regained his pre-injury functional status after physiotherapy, use of prescription medications, and individual psychotherapy. 7 Mr. has motivation to change, is willing to change his medication regimen, and is aware that successful treatment may change secondary gains. 8(a) Mr. indicated that his relationship with his employer before the injury was good. 8(b) he states that he was happy at his job before the injury. 8(c) Mr. does not endorse a negative outlook about his future employability. 8(d) See the summary of psychological testing results chart. 8(e) He is involved in financial disputes with his carrier. 8(f) The patient does not smoke. 8(g) Mr. has not worked since 6/27/11. However, he is both motivated and optimistic about recovery with treatment. 8(h) Mr. is not using prescription opioids beyond his prescribed dosage. 8(i) Mr. does not have extraordinary levels of pain. He rates this as 8/10, depending on his level of activity.

On October 5, 2011, PhD performed a UR on the claimant. Rationale for Denial: The clinical indication and necessity of this procedure could not be established.

The mental health evaluation of 9/22 finds impression of pain disorder. However, this is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. Adequate explanation for the continuing pain reported is lacking; and Dr. now offering "several treatments and denial of additional PT" is a tautology, not an explanation. This is significant, given conclusions of the peer review. It is unclear what medications the patient is using. More recent medical visit data could not be provided. This is not an appropriate context in which to initiate a tertiary pain management program. There is no documentation or known finding that the patient's treating physician (Dr.) has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. This is not addressed in his last note of 8/29; and further medical documentation could not be found (though Dr. did search for it). A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, without these assessments.

On October 17, 2011, a reconsideration request for chronic pain management program by PhD . In response to Dr. rationale for denial: Patient is taking Tramadol 50 mg bid and Motrin 800 mg qid. Dr. requested 12 sessions of physical therapy on 7/27/11 but this was denied. Psychological testing was conducted on 9/22/11 and this report was included in the pre-authorization packet. The patient did not over report symptoms. He did tend to portray himself in apposite light due to his background stressing traditional values. Individual therapy was denied at the IRO level. He has done two injections for his lumbar spine. They only provided relief for about 1-2 weeks. A third one was not requested. Dr. has recommended chronic pain and has ruled out other treatment options.

On November 4, 2011, PhD performed a UR on the claimant. Rationale for Denial: The initial review cites several deficiencies in the initial request for services. The additional documentation provided in the appeals correspondence did not adequately address these deficiencies and did not impact the prior recommendation for non-authorization. The "duration" of this injury and his "over-reporting" of psychological symptoms which are negative predictors of success are not addressed in the evaluation as required by current guidelines (work loss data institute, ODG, 2011). There is no evidence provided to indicate that the treatment team has exhausted all appropriate treatments for this patient, a clinical indication for a chronic pain management program. Thus, the request is inconsistent with the requirements that "there is an absence of other options likely to result in significant clinical improvement" and "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". Based on the documentation provided, ODG criteria were not met.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

Denial of Chronic Pain Management is upheld/agreed upon. Clinical information regarding the original injury and subsequent timely work up and treatment and functional disposition is lacking. The injury was in xxxx and the submitted clinicals are dated 2011. There is question as to the previous work up and treatment during this 4 year interval. I also agree with the previous URs reasoning for denial based on ODG criterion not being met.

### **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).

(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](#).

## IRO REVIEWER REPORT TEMPLATE -WC

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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)