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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The medical necessity of proposed 10 days (5 wk X2 wk) of a chronic pain management program

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

REVIEW OUTCOME

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

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

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	97799		Prosp	10					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained a work-related injury on xx/xx/xx. Initial evaluation of 11/8/2010 submitted for review states that claimant was injured while performing her usual job duties which included xxx. She was sitting in a chair which was missing a wheel, and as she rolled back, she fell out of the chair, landing on her right side on top of the armrest. Patient is currently in a pre-surgical status and has not returned to work.

Patient has received numerous diagnostics and interventions since her injury to include: X-rays, MRI's CT scan, FCE, physical therapy, TENS unit, ESI's, and medication management to include Metformin, Lisinopril, and Flexeril. Patient is diagnosed with L4-5 HNP, L4-5 central and foraminal stenosis, segmental instability, radiculopathy, exogenous obesity, and probable sacroiliac joint dysfunction.

Current request is for 80 hours of a chronic pain/functional restoration program to address pre-surgical referral for weight loss and smoking cessation, among other issues. At the time of the initial interview, patient scored a 25 on the BDI and rated her pain at an 8/10. FABQ was 21/35, Sleep Questionnaire score was severe, and Oswestry was 70%. Patient is smoking 4 cigarettes per day, and would like to lose approximately 40 pounds. Interdisciplinary goals are: reduce body fat to 20 percent or less, and address issues of: unrealistic expectations of surgery, chronic pain behaviors, disability management, decreased overall conditioning, psychosocial stressors, depressed mood, and titration of medications. Patient was diagnosed with 307.89 Pain Disorder and V62.2 Occupational problem. Axis II was deferred.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Patient requires low back surgery, but will not be an appropriate candidate for successful surgery until numerous multi-dimensional symptoms of obesity, intense pain perception; fears of re-injury, depression, and addiction to cigarettes are addressed. This patient is appropriate for the requested 10-day program to address these issues and insure a successful surgical outcome and quick recovery and return to work.

FRP's: Recommended for selected patients with low back pain and chronic disabling back pain, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. The evidence base in other conditions is unclear. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see [Chronic pain programs](#)), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. ([Bendix, 1998](#)) A Cochrane

review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. ([Guzman 2001](#)) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. ([Airaksinen, 2006](#)) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. ([Karjalainen, 2003](#)) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see [Chronic pain programs](#).

Criteria for the general use of multidisciplinary pain management programs 2010 Pain Chapter:

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 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](#)

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came

late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. ([WCRI, 2005](#)) ([Joling, 2006](#)) ([PERI, 2005](#)) ([Smith, 2001](#)) ([Stover, 2007](#))
Delayed recovery has been associated with delayed referral to nurse case management. ([Pransky, 2006](#))

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

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES