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Notice of Independent Review Decision

DATE OF REVIEW: July 12, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5 x week x 2 weeks = 10 sessions

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

International Neuropsychological Society

American Psychological Association

Listed in the National Register of Health Service Providers of Psychology

REVIEW OUTCOME

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

Overtured (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained injury on xx/xx/xx, while working as a xx. She was helping a xx on a rainy day when the xx slipped backwards into her causing her to fall backwards. She did not fall completely to the ground but hit her shoulder on the railing causing extreme pain. She also sustained injury to her lumbar, sacrum left arm and left hip.

Ph.D., noted the patient had received several levels of treatment including magnetic resonance imaging (MRI), physical therapy (PT), chiropractic, pain injections and medications; however, none had seem completely successful in lowering her pain levels. Her Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) score were 42 and 20 respectively. Dr. diagnosed adjustment disorder with mixed anxiety and depressed mood pain disorder and chronic pain. He recommended participation in multidisciplinary chronic pain management program (CPMP) to aid her in dealing with depression, anxiety and pain symptoms. The patient had undergone individual psychotherapy sessions. She had not been able to become stabilized enough to enhance coping mechanisms

to more effectively manage pain and achieve success and rehabilitation. It was crucial that the patient receive another necessary component, which was not provided in individual therapy, to help obtain the tools needed to succeed and increase overall level of functioning. In multidisciplinary CPMP, she would receive the tools needed to remove or address both psychological and physical barriers such as improving coping skills, social skills, social support, improve self esteem, increase level of functioning, improve vocationally and interpersonally, manage more effectively stress related issues, address self defeating thoughts, help stay motivated and consistent with goals, decrease dependency on health care system, improve functioning interpersonally, minimize distress caused by anxiety and depression related to chronic pain and control over emotions and fears of the future. Hence, Dr. recommended outpatient CPMP five times a week for two weeks to achieve primary goals of decrease BAI score, decrease sleep questionnaire, develop an appropriate vocational plan, and increase the ability to return to fullest functional restoration and increase the ability to manage pain and reduce pain level.

A comprehensive functional capacity evaluation (FCE) revealed the patient was capable of performing in the sedentary physical demand level (PDL) as against her job required PDL of medium. She did not meet her pre-injury lifting demand. The evaluator recommended her to transition to CPMP to address her overlying deficits.

M.D., denied the request for ten sessions of CPMP based on the following rationale; *"In the evaluation Dr. indicated that this individual required additional evaluation and treatment both of her lumbar spine and left shoulder. She did undergo and MRI of the left shoulder which showed rotator cuff tendopathy. However there is no indication of any further treatment with regard to the shoulder or low back. The notes from the pain management program evaluation indicate that this individual has chronic pain as well as psychological factors that are affecting her ability to recover. However despite extensive notes from Dr. there is no indication of the subsequent treatment of this individual other that she has had MRIs, physical therapy, chiropractic care, pain injections, and medications. There are no details available to indicate whether this individual has had adequate orthopedic evaluation and treatment with regards to her left shoulder or her low back. Based on the lack of adequate documentation of conservative care and treatment the request for an interdisciplinary pain management program is recommended for non certification as medically not necessary or appropriate."*

D.C., in a request for reconsideration opined that the patient had exhausted all lower levels of care and was pending no additional procedures. Per official disability guidelines (ODG), patients who did not complete a chronic pain program were seven times more likely to have post-rehabilitation surgery in the same area and nearly seven times more likely to have more than 30 visits to a new health provider in persistent healthcare seeking efforts. The study also demonstrated that the patient who does not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and seven times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program was the recommended course of treatment to help the patient return to work.

M.D., denied appeal for ten sessions of CPMP based on the following rationale; *“The claimant is a female whose date of injury is reported as xx/xx/xx. The claimant has not done work hardening or work conditioning, is presently only on Naprosyn for pain and is not on any narcotics, no injections have been done, only physical therapy. There is no current physical exam from an orthopedist documenting functional deficits requiring a functional restoration program. All lower level of cardiopulmonary has not been exhausted and the request is recommended for non certification.”*

On June 28, 2011, Dr. in a request of medical dispute resolution opined the patient pain rehabilitation program could be consider medical necessary in the following circumstance; (1) The patient has a chronic pain syndrome, with evidence of loss of function and was beyond three months. (2) Previous methods of treating chronic pain have been unsuccessful. (3) An adequate and through multidisciplinary evaluation had been made. (4) To avoid controversial or optional surgery. (5) Documentation that the patient has motivation to change. (6) Negative predictors of success have been addressed. (5) Total treatment duration should generally not exceed 20 full day sessions. The patient qualifies for this program based on the accepted clinical guidelines and practice standards and this letter was imitated to process of medical disputes regulations.

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

THE CLAIMANT SUFFERED AN INJURY TO HER SHOULDER AND BACK. SHE WAS TREATED WITH VARIOUS PRIMARY TREATMENTS. HER TREATING PHYSICIANS STATED THAT ALL APPROPRIATE TREATMENTS HAD BEEN EXHAUSTED AND NO FURTHER TREATMENTS WERE PLANNED. SHE CONTINUED TO COMPLAIN OF PAIN AND A CHRONIC PAIN DISORDER WAS DIAGNOSED. THE REQUEST FOR 10 SESSIONS OF CHRONIC PAIN MANAGEMENT PROGRAM WAS DENIED BECAUSE THE REVIEWER OPINED THAT OTHER LOWER LEVELS OF CARE SHOULD BE ATTEMPTED. IN REQUEST FOR RECONSIDERATION, THE PROVIDER ARGUED THAT ALL ALTERNATIVE TREATMENTS WERE CONSIDERED AND ADDITIONAL PRIMARY TREATMENT WAS FELT TO BE UNNECESSARY. THE APPEAL REVIEWER OPINED THAT WORK HARDENING AND WORK CONDITIONING SHOULD BE TRIED BEFORE A CHRONIC PAIN MANAGEMENT PROGRAM AND DENIED THE APPEAL.

IT IS MY OPINION THAT THE REQUEST FOR A CHRONIC PAIN MANAGEMENT PROGRAM DOES MEET THE ODG FOR MEDICAL NECESSITY AND THUS THE DENIAL SHOULD BE OVER TURNED. THE TREATMENT REPORTED APPEARS TO HAVE MET THE ODG FOR TREATMENT OF THE INJURY. THE ODG DOES NOT RECOMMEND THAT WORK HARDENING OR WORK CONDITIONING BE ATTEMPTED BEFORE A CHRONIC PAIN MANAGEMENT PROGRAM. AS NOTED BELOW THE CHOICE OF ANY OF THESE PROGRAMS IS MADE BY THE CLINICIAN AND SHOULD BE SUPPORTED IN THE TREATMENT PLAN. I WOULD AGREE THAT THOSE CONSIDERATIONS WERE ADDRESSED AND A CHRONIC PAIN MANAGEMENT PROGRAM WAS CHOSEN AS THE TREATMENT THAT WOULD MOST LIKELY BE SUCCESSFUL AS COMPARED TO THE OTHER ALTERNATIVES.

THE REQUEST FOR 10 SESSIONS CHRONIC PAIN MANAGEMENT PROGRAM MEETS THE FOLLOWING ODG GUIDELINE FOR TREATING CHRONIC PAIN.

ODG 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 healthcare 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 pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (3) 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 loss 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.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES