

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West El Dorado Pkwy · Suite 100 – 373 · McKinney, Texas 75070

Office 469-218-1010 · Toll Free 1-877-861-1442 · Fax 469-218-1030

e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 07/21/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic Pain Mgmt. Program 80 hours

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Designated Doctor Evaluation by Dr. on 10/08/2010
2. Request for preauthorization dated 03/31/2011
3. Functional capacity evaluation dated 04/05/2011
4. Physical assessment evaluation dated 04/06/2011
5. Appeal letter dated 05/12/2011
6. Request for review by an IRO dated 07/02/2011
7. Prior reviews dated 04/25/2011 and 05/23/2011
8. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who sustained an injury on xx/xx/xx. Designated Doctor Evaluation dated 10/08/2010 reported the patient was injured while lifting an object when she fell. The patient

complained of initial severe left lower extremity pain and swelling. The note reported the patient had been previously treated with medications and a course of physical therapy.

Requests for preauthorization dated 03/31/2011 reported the patient had completed 10 days of a chronic pain management program with improvement. The note reported the patient had discontinued the use of Hydrocodone, was not longer wearing an ankle-stabilizing boot, and had increased daily activity level. The note reported the patient had a BDI-2 score of 26 and BAI score of 21.

Functional capacity evaluation dated 04/05/2011 reported the patient had an increased physical demand level from sedentary to light.

Prior review on 04/25/2011 by Dr. reported the request for continuation of a chronic pain medical program for 10 additional sessions was denied. Dr. cited rationale for denial as it had been 4 months since the patient had originally participated in the program and with documentation that the patient was no longer taking medications and had returned to work.

Appeal letter dated 05/12/2011 reported the patient returned to work shortly after completing the 1st 10 sessions of treatment with restrictions. The note reported the patient worked several months before being informed by her employer that she could not continue to work until returning to full duty. The patient was again recommended for additional sessions of an interdisciplinary chronic pain management program to allow for return to full duty.

Prior review dated 05/23/2011 by Dr. per the request for 10 additional sessions was denied. Dr. stated his rationale for denial was inconsistency with *Official Disability Guidelines* as treatment was provided in a “split” fashion and not continuous.

Request for review by an IRO dated 07/02/2011 reported the patient made the decision to return to work on her own volition and it was not recommended from the treatment team that she was ready for discharge. The patient was recommended for additional treatment.

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

The request for chronic pain management program for 80 hours is not medically necessary. The patient completed 10 sessions of a chronic pain management program in December of 2010. The patient was noted to increase physical demand level from sedentary to light and discontinue intake of Hydrocodone. There was no indication the patient reduced psychometric testing scores. Documentation indicates the patient attempted a return to work with restrictions after completion of the initial 80 hours of treatment. The request for continuation of care was deemed not necessary twice given the duration in between the 2 courses of treatment. *Official Disability Guidelines* state that at the conclusion of a chronic pain management program, re-enrollment in a similar program is not warranted for the same condition or injury. Given that the patient's treatment was stopped and there has been a 7 month gap since previous treatment, re-enrollment in a chronic pain management program for 10 additional sessions would not be warranted at this time.

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

Official Disability Guidelines, 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 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).