

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/02/11

**IRO CASE NO.:**

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

Item in dispute: Chronic pain management program 10 days CPT 97799

**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**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is female who sustained an injury on xx/xx/xx when she slipped and fell, causing pain to the left wrist.

The employee saw Dr. on 03/11/10. The employee complained of cervical pain, left arm pain, and chronic pain rating 7 to 10 out of 10. Physical examination revealed some discoloration of the hand. Range of motion was decreased. There was some swelling of the left wrist. The employee was assessed with cervicalgia, cervical radiculopathy, sympathetically mediated pain, and reflex sympathetic dystrophy. The employee was recommended for a stellate ganglion block.

The employee saw Dr. on 03/22/10 with complaints of pain in the left upper extremity with numbness of the hand. The note stated there was a bluish discoloration of the left upper extremity. Physical examination revealed decreased range of motion of the left shoulder and cervical spine. There was weakness of the left shoulder and loss of the left triceps deep tendon reflex. There was bluish discoloration and edema of the left upper extremity. The employee was not placed at Maximum Medical Improvement (MMI). The employee was recommended for MRI of the left shoulder, MRI of the cervical spine, and epidural steroid injection.

The employee saw Dr. on 04/29/10. The employee complained of upper extremity pain rating 7 to 9 out of 10. Physical examination revealed no specific area of lumbar tenderness. The extremities show classic allodynic and hyperpathic response of the signs and symptoms. There was increased sensitivity to touch. Strength was diminished in the bilateral upper extremities. The employee was assessed with complex regional pain syndrome and reflex sympathetic dystrophy of the upper extremities, left worse than right. The employee was recommended for psychological evaluation followed by trial neuromodulation. The employee was prescribed Lyrica, Cymbalta, and Nortriptyline.

The employee saw Dr. on 05/29/10 with complaints of left upper extremity pain. The employee reported severe pain to the medial aspect of the left elbow along with swelling and inflammation. The employee rated the pain at 10 out of 10. The employee also reported severe pain to the posterior aspect of the left shoulder, rating 10 out of 10. The employee reported extreme sensitivity to light touch along the entire left upper extremity and weakness of the left upper extremity. Current medications included Lyrica, Cymbalta, Nortriptyline, and Darvocet-N 100. Physical examination revealed moderate cervical spine tenderness. There was severe left posterior shoulder tenderness along the supraspinatus tendon area. There was severe tenderness over the anterior acromioclavicular joint and "excruciating" tenderness along the left medial elbow with marked inflammatory changes. There was moderate tenderness along the left volar forearm, hand, and wrist. The employee was assessed with left shoulder strain, medial epicondylitis of the left elbow, and rule out chronic regional pain syndrome Type I. The employee was recommended for MRI of the left shoulder and psychological consultation. The employee was prescribed Lortab, Medrol Dosepak, Cymbalta, Lyrica, and Ambien.

The employee was seen for mental health evaluation on 07/06/10. The employee complained of left upper extremity pain rating 10 out of 10. The note stated the left arm was swollen and the veins are visible. Current medications included Norco, Lyrica, Cymbalta, Ambien, and Xanax. The employee stated she was unable to assist with household duties, to include cooking and cleaning. The employee reported weight loss of 25 pounds. The employee reported no current or past suicidal ideations. The employee was assessed with adjustment disorder with mixed anxiety and depressed mood and pain disorder associated with both psychological factors and a general medical condition. The employee was recommended for six sessions of psychotherapy.

The employee saw Dr. on 10/26/10 with complaints of pain in the left upper extremity from the shoulder to the wrist. Current medications included Lortab, Medrol Dosepak, Cymbalta, Lyrica, and Ambien CR. Physical examination revealed no muscle spasm of the cervical spine. There was left paracervical muscular tenderness. There was no suboccipital tenderness. Spurling's was negative. Hoffman was negative. Cervical range of motion revealed flexion to 50 degrees, extension to 70 degrees, right lateral flexion to 44 degrees, and left lateral flexion to 45 degrees. Deep tendon reflexes were 0/4 of the biceps, triceps, and brachioradialis. Examination of the left shoulder revealed generalized tenderness to palpation over the acromioclavicular joint. There was posterior, anterior, and lateral shoulder joint tenderness. There was medial and lateral epicondylar tenderness. There was no tenderness over the radial tunnel. Tinel's was negative. The employee was assessed with chronic pain syndrome. The employee was recommended for a spinal cord stimulator trial and participation in a chronic pain management program.

A Functional Capacity Evaluation (FCE) was performed on 01/18/11. The employee's

occupation as a required a light to medium physical demand level. The employee was currently performing at a less than sedentary to sedentary-light physical demand level. The report stated the employee did not meet the requirements to safely perform her job, and she should not return to work at this time. The employee was recommended for a chronic pain management program.

The employee was seen for mental health evaluation on 03/30/11. The employee complained of mood disturbances, psychosocial stressors, chronic pain, and physical limitations. Current medications included Lyrica, Norco, Cymbalta, and Ambien CR. The employee's BDI score was 28, indicating moderate to severe depression. The employee's BAI score was 22, indicating moderate anxiety. The employee scored a 35 on the sleep questionnaire, indicating mild sleep disturbance. The employee's GAF score was 52. The employee was recommended for a multidisciplinary chronic pain management program.

The request for chronic pain management program was denied by utilization review on 04/01/11, but the reasoning for the adverse determination was not provided for review.

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

The requested chronic pain management program x 10 days is not recommended as medically necessary. The clinical documentation does indicate the employee has completed several conservative treatments. The employee does exhibit significant psychological difficulties that would reasonably require further treatment. The clinical documentation provided for review does not indicate the employee's response to individual psychotherapy. Only one individual psychotherapy note was provided for review, and no summary evaluation of the employee's response to therapy was provided. It is unclear whether the employee attempted any psychotropic medication trials. It is also unclear if the employee has been ruled out as a surgical candidate. The employee has also been recommended for a spinal cord stimulator, and it is unclear if the employee has decided to not pursue this treatment.

As the clinical documentation provided for review does not meet guideline indications for the request, medical necessity is not established.

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

#### **1. Official Disability Guidelines, Online Version, 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 examination 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).