

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

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/27/11

**IRO CASE NO.:**

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

Item in dispute: 97799 Chronic pain management program x 80 hours

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

Texas Board Certified Physical Medicine & Rehabilitation

**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. Clinical notes dated 09/24/08-05/12/11
2. MRI cervical spine dated 01/21/10
3. Electrodiagnostic study of the upper extremities dated 01/21/10
4. Prior reviews dated 04/08/11 and 05/03/11
5. Cover sheet, working documents and duplicates.
6. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on xx/xx/xx.

The Employer's First Report of Injury or Illness form dated xx/xx/xx reported the employee was injured secondary to working on metal shelves and tables in the produce department.

A clinical note dated 03/30/09 reported the employee complained of neck and right upper back pain with right hand numbness and right arm pain.

Notes reported the employee had completed a course of physical therapy with some decrease in pain.

A clinical note dated 01/07/10 reported the employee stated she could not use her hands or right upper extremity. Physical examination reported "questionable hyposensitivity in the C5-C6-C7 and C8 dermatome of the right upper extremities."

An MRI of the cervical spine dated 01/21/10 revealed findings of 1 mm disc bulges at C4-C5 and C5-C6.

An Electrodiagnostic study of the upper extremities dated 01/21/11 revealed findings of mild right carpal tunnel syndrome and right C5-C6 nerve root irritation.

A clinical note dated 03/23/10 reported the employee complained of pain in the right upper extremity, arm and shoulder. The note reported the employee was wearing cock-up splints at night with continued numbness and tingling sensation intermittently. The employee refused injection and was recommended for a second opinion and continued medication management.

A clinical note dated 05/21/10 reported the employee had moderate atrophy of the thenar eminence on physical examination as well as positive Phalen's and Tinel's sign. The employee was recommended for carpal tunnel release.

A clinical note dated 02/24/11 reported the employee had not undergone surgical intervention.

Work capacity evaluation dated 03/25/2011 reported the employee required a heavy physical demand level. Testing revealed the employee had a physical demand level of sedentary.

A behavioral evaluation report dated 03/25/11 reported the employee had a BDI-II score of 20 and BAI score of 22.

A letter dated 04/01/11 recommended the employee was to complete eight hours of a chronic pain management program.

A prior physician review dated 04/08/11 by Dr. denied the request for a chronic pain management program. It appears the denial was based on the employee's lack of working since five months status post injury, lack of treatment since 2010, and significant gaps in care.

A letter for reconsideration dated 04/27/11 reported the employee had been treated with medications, therapy, and physical rehabilitation. The note reported the employee was also taking antidepressant medication to include Cymbalta. The employee was again recommended for a chronic pain management program.

There was a prior physician review dated 05/03/11 by Dr. for a chronic pain management program. It appears the request was denied secondary to the employee's lack of working, lack of treatment from 2008 to 2010, invalid work capacity evaluation, and the employee's plan of treatment.

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

The employee sustained an injury on xx/xx/xx. There is a lack of documentation of recent conservative treatment. The employee was also previously recommended for a right carpal tunnel release. There is no indication that the employee has been currently ruled as a surgical candidate. In addition, reasons for prior denials were not rebutted from the requesting provider. As such, the clinical documentation provided does not support the medical necessity of the request 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).