

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 10/20/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: outpatient chronic pain management program, five (5) 8 -hour sessions per week, over two (2) weeks, as related to the lumbar spine.

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

Texas Board Certified Psychiatrist

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. Includes a functional capacity evaluation dated 08/17/11
2. Clinical notes dated 05/13/10 through 09/01/11
3. Operative reports dated 10/13/10 and 07/20/09
4. An x-ray of the lumbar spine dated 03/28/11
5. A MRI of the left shoulder dated 03/10/09
6. MRI of the lumbar spine dated 02/14/11
7. Electrodiagnostic studies of the lower extremities dated 06/04/09
8. Operative reports dated 07/20/09 of the left shoulder rotator cuff and L4-L5, L5-S1
9. Hemilaminectomy on 10/13/10
10. Previous utilization reviews dated 09/12/11 and 09/26/11
11. An appeal letter, 09/14/11
12. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male who sustained an injury to his low back when he fell while back. The clinical note dated 05/13/2010 details the patient continuing to complain of ongoing low back pain as well as left shoulder pain. The patient rated the pain as 7/10 at that

time. The note details the patient having previously undergone an epidural steroid injection with no significant relief. The patient was also noted to have completed 10 sessions of a work hardening program which exacerbated his back pain. The operative report dated 10/13/2010 details the patient undergoing an L4-5 and L5-S1 hemilaminectomy, and medial facetectomy and a left sided foraminotomy. The MRI of the lumbar spine dated 02/14/2011 revealed post surgical changes as well as no evidence of recurrent disc herniations. The x-ray of the lumbar spine dated 03/28/2011 revealed hypertrophic changes at the L5-S1 facet joints. The clinical note dated 03/03/2011 details the patient presenting with complete foot drop on the left side. The functional capacity evaluation dated 08/17/2011 details the patient able to perform at a medium PDL; however, the patient's work requires a very heavy PDL. If the patient was able to demonstrate 4/5 strength throughout the lumbar region and 5/5 strength related to the shoulder region. The clinical note dated 08/19/2011 details the patient having completed 6 sessions of individual counseling related to elevated BDI and BAI scores. The patient was also noted to be undergoing pharmacological interventions for ongoing pain relief. The clinical note dated 09/01/2011 details the patient continuing with complaints of low back pain he rated as 8/10. The note further details the patient able to sleep approximately 4-6 hours each night. The patient's BDI-2 score was noted to be 49 on 09/01/2011 revealing severe levels of depression. The patient's BAI score was noted to be 32 on the same date which revealed severe levels of anxiety.

The previous utilization review dated 09/12/2011 details the patient having been denied inclusion into a chronic pain management program on the basis of a lack of information regarding the patient's updated psychological screening. The previous screening revealed severe depressive and anxiety symptoms. The previous utilization review dated 09/26/2011, details the patient being denied inclusion into a chronic pain management program secondary to the severe levels of both anxiety and depression.

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

The request for a chronic pain management program 5 eight hour sessions per week over 2 weeks as related to the lumbar spine is non-certified. The documentation details the patient having undergone psychological evaluations as part of the functional capacity evaluation which revealed significantly elevated levels of both depression and anxiety. The ***Official Disability Guidelines*** recommend a chronic pain management program provided the patient has previously exhausted all methods of treating chronic pain. The documentation details the patient having previously undergone 6 sessions of mental health therapy; however, the documentation details the patient continuing with severely elevated depressive and levels of anxiety. Given the elevated scores regarding the patient's severely BAI and BDI, this request does not meet guideline recommendations. As such, the documentation submitted for this review does not support 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, Online Version:

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).