

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of Chronic Pain Management

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 15 year experience.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

10-21-2010: Report of Medical Evaluation performed by MD

04-11-2011: Independent Medical Evaluation Performed by M.D.

05-19-2011: Medical clearance at Allied Medical Centers, performed by M.D.

05-19-2011: Rehabilitation, Team Treatment Plan, performed by Ph. D.

05-19-2011: Rehabilitation, Psychological Diagnostic Interview, preformed by Ph. D.

07-12-2011: Oswestry Low Back Pain Disability Questionnaire

07-12-2011: Functional Abilities Evaluation

08-24-2011: Rehabilitation, Request for Reconsideration, by Ph. D.

08-16-2011: Ph. D. performed UR on the claimant

09-01-2011: PH. D. performed UR on the claimant

PATIENT CLINICAL HISTORY [SUMMARY]:

A woman injured on the job on xx/xx/xxxx. At that time, she was stacking heavy merchandise on top of a water pallet. She bent down to wrap the pallet and felt pain in her lower back.

10-21-2010: Report of Medical Evaluation performed by MD to determinate whether claimant is at Maximum Medical Improvement (MMI). Dr. reports that the claimant was first seen by Dr. on 07-09-2010, who noted that physical exam revealed tenderness on palpation of the lumbar. SLR and reflexes wee normal in both lower extremities. Dr. diagnosed claimant with a lumbar sprain and lumbago. She was prescribed pain meds, as well as NSAID, and referred for PT. Dr. also noted the following: On 08-04-2010: Claimant was 50% improvement with back pain with PT, with resolution of aching in her LB. On 08-18-2010: Claimant was 90% improved. Dr. performed a DDE, finding her at MMI as of 08-18-2010. On 08-23-2010: Claimant reported a recurrence of LBP after returning back to work. Physical exam revealed normal reflexes and SLR. Dr. ordered MRI.

On 09-08-2010: It was noted that claimant was seen by Dr. DC. On 09-01-2010: Claimant reports LBP with new onset of right upper back pain. MRI was performed on 09-08-2010 and showed multi-level degenerative changes. On 09-29-2010: Claimant was referred to pain management. In Dr. clinical evaluation on 10-21-2010 notes the claimant reports bilateral low back pain, radiating to the buttocks, exacerbated by bending. Impression: the clinical condition is stabilized and not likely to improve with surgical intervention or active medical treatment; medical maintenance care only. Regarding the ability of the claimant to return to work, the relevant guide lines do not support either work restrictions or off work status at this point,

04-11-2011: Independent Medical Evaluation Performed by M.D. Diagnoses included: 1. Strain/Strain of the lumbar spine, related to the injury of June 30, 2010. 2. Persistent symptoms with no apparent physiologic cause. 3. Lumbar degenerative disc disease, not aggravated by, nor created by the injury in question. Impression: Current treatment is not appropriate; no further care would be reasonable or necessary.

05-19-2011: Medical clearance at Medical Centers, performed by M.D. recommended that the claimant participate in a trail of CPMP. She demonstrated functional and psychological deficits outlined by physical and psychometric testing and will benefit from a multispecialty program.

05-19-2011: Rehabilitation, Team Treatment Plan, preformed by Ph. D. notes that the claimant is an individual with a complex interplay of psychological and physiological symptoms that tend to respond more favorably and rapidly to an Interdisciplinary Chronic Pain Management Program. Estimated length of treatment being 10 days.

05-19-2011: Rehabilitation, Psychological Diagnostic Interview, performed by Ph. D. Impression: Axis I: 307.89 Pain Disorder Associated with both Psychological Factors and a General Medical Condition. Axis II: V71.09Deferred. Axis III: Lumbar inter vertebral without myelopathy; sprain/strain of lumbar region. Axis IV: Psychosocial Stress is severe. Axis V: GAF: current=65, pre-injury=83. Plan: Dr. recommended 10 sessions of treatment in an interdisciplinary pain management program.

07-12-2011: Oswestry Low Back Pain Disability Questionnaire was completed. Total score was 28 which by description are; back pain impinges on all aspects of the claimant at home and at work and positive intervention is required.

07-12-2011: Functional Abilities Evaluation to determine claimants current functional and return to work status. Results revealed that claimant's was able to safely and dependably perform the demands of claimants occupation.

08-24-2011: Qualcare Rehabilitation, Request for Reconsideration, by Ph. D stating claimant does meet the ODG criteria, and fails to meet the minimum requirements for her position.

08-16-2011: Ph. D. performed UR on the claimant. Rationale for Denial: Claimant has been certified at MMI with 0% rating and full duty release as of 08-18-2010, and no surgical intervention or active medical treatment is warranted. Therefore 10 sessions of a chronic pain management program in not medically necessary or appropriate.

09-01-2011: PH. D. performed UR on the claimant. Rationale for Denial: The claimant has been placed at MMI with 0% whole person impairment and has been determined to be capable of return to full duty work. Therefore the request is not supported or medically necessary.

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

Decision to deny CPM is upheld /agreed upon per the ODG pain management chapter. The criterion (1) was not met. The FLE demonstrates ability to perform the demands of the claimant's occupation, therefore failed to document loss of function.

PER THE ODG:

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).

(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). See [Chronic pain programs, opioids; Functional restoration programs.](#)

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)