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Notice of Independent Review Decision

DATE OF REVIEW: 09/19/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chronic pain management 5 x 2, wrist 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

1. Functional Capacity Evaluation intake and comprehensive Functional Capacity Evaluation dated 07/14/11
2. An evaluation for the chronic pain management program dated 06/08/11
3. Clinical note dated 09/06/11
4. Previous reviews dated 08/09/11 and 08/29/11
5. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee sustained an injury on xx/xx/xxxx.

The employee was referred for the chronic pain management program for a total of ten sessions. According to chronic pain management evaluation dated 06/08/11, the employee reported the primary location of his pain was in his right wrist. The employee stated his pain was a 7/10. The employee reported that his largest worry was never being able to return to work because of his hand. The employee underwent the BDI-2 and scored a 51. The employee underwent the BAI and scored a 48. The employee was reported to be on Hydrocodone and Gabapentin.

According to the comprehensive Functional Capacity Evaluation (FCE) dated 07/14/11 reported the employee was able to improve his physical demand level from a less than sedentary to a light physical demand level, and then to a medium physical demand level.

According to the prior reviews dated 08/09/11, the employee was denied for the chronic pain management program due to no thorough behavioral psychological examination provided with clinical documentation. There was no current history and physical by the medical directory or physicians associated with the pain program. There was no documentation on known finding that the employee's treating physician has currently ruled out all other appropriate care for the chronic pain problem. There was no examination by any physician who would provide medical supervision of narcotic withdrawal and no pain or protocol for doing this.

The previous review dated 08/29/11 denied the employee of the chronic pain management program due to the lack of documentation that stated all diagnostic procedures necessary to rule out and treat able pathology, including imaging studies and invasive injections were not provided. The employee was also denied due to the employee's injury being over two years old. The request was inconsistent with the requirement that if the program is planned for a employee that has been continuously disabled for greater than twenty-four 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.

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

Based on the previous reviewer's determinations to non-certified the employee for a chronic pain management program 5 x 2 for the wrist is agreed upon. The previous reviewer's denied the employee for lack of clinical documentation provided of recent physical examination that ruled out conditions that require treatment prior to initiating the program. There was lack of evidence provided to indicate that the employee had exhausted all appropriate treatments, a clinical indication for chronic pain management program. The injury was over two years old. There was lack of a thorough behavioral psychological examination. The clinical documentation provided still lacks a recent physical examination, thorough psychological examination and evidence provided to indicate that the treatment team has exhausted all appropriate treatments for the employee. Therefore, the request for chronic pain management program 5 x 2 to the wrist is non-certified.

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).