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Notice of Independent Review Decision

DATE: 07/16/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of Chronic Pain Management Program.

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

Board Certified Family Practice

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 10/12/2011, 10/14/2011, 11/01/2011, 11/03/2011, 11/08/2011, 11/10/2011, 11/11/2011, 11/14/2011, 02/10/2012, 02/13/2012, 02/15/2012 and 02/21/2012, daily physical therapy notes.
2. 11/14/2011, 11/23/2011, 01/19/2012, 01/20/2012, 02/21/2012, 02/29/2012, 03/07/2012, clinical notes, DC.
3. 02/24/2012, Independent Medical Examination, MD.
4. 04/30/2012, letter, DC.
5. 05/14/2012, Designated Doctor Evaluation, , MD.
6. 05/24/2012, Work Capacity Evaluation, Unknown author.
7. 05/24/2012, Initial Medical Report, MD.
8. 05/24/2012, Behavioral Evaluation Report, LPC.
9. 06/01/2012, Pre-authorization Request, MD.
10. 06/07/2012, Peer Review, MD.
11. 06/08/2012, Adverse Determination Letter, MD.
12. 06/08/2012, Request for Reconsideration, MD.
13. 06/11/2012, PLN 11 Form, Unknown Author.
14. 06/18/2012, Adverse Determination Letter, Ph.D.
15. 06/27/2012, Letter, MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who reported an injury on xx/xx/xx. An office visit with, DC on 11/14/2011 reported the claimant had completed 12 sessions of therapy with continued ongoing low back pain and radiation to the lower extremity. Examination revealed 46 degrees of flexion and 17 degrees of extension. The claimant was recommended for a Functional Capacity Evaluation and possible work conditioning program. A follow-up with Dr. on 12/23/2011 reported the claimant was status post an injection and remained symptomatic at the shoulder. Exam revealed positive impingement signs with slightly increased range of motion. The claimant was also noted to have palpable spasms over the supraspinatus. That note mentioned that the claimant had positive lumbar disc pathology at L4-5 identified on an MRI. The claimant was recommended to continue with therapy. Follow-up on 01/19/2012 reported the claimant had an outbreak of shingles on the right side at T10. The patient went to the emergency room and was being treated with medication management.

An Independent Medical Examination on 02/24/2012 by Dr. reported the claimant was injured when he was driving an 18-wheeler truck and was rear-ended by another 18-wheeler truck at high speed, injuring his low back, neck and left shoulder. The claimant complained of 7/10 low back, neck and left shoulder pain. Physical examination revealed decreased left shoulder range of motion and motor strength. The claimant also had decreased lumbar spine range of motion. The provider indicated that the extent of the injury would include left shoulder impingement syndrome and sprain/strain injuries of the lumbar spine, cervical spine and left shoulder. A follow-up with Dr. on 03/05/2012 reported that he had completed a FCE that revealed a light sedentary Physical Demand Level. The note reported the claimant was scheduled for a lumbar epidural steroid injection on 03/21/2012 and was being recommended for 4 additional post injection therapy sections.

A Designated Doctor Evaluation with Dr. on 05/14/2012 reported that the claimant's prior treatment had consisted of 14 weeks of physical therapy and chiropractic care, as well as a cortisone injection to the left shoulder. The note reported the claimant had reached MMI and was given a 5% impairment rating for the cervical and lumbar spine. The note reported the claimant had not reached MMI for the left shoulder. A Work Capacity Evaluation dated 05/24/2012 reported that the claimant required a heavy Physical Demand Level and testing indicated that he had a Physical Demand Level of sedentary-light. A Behavioral Evaluation dated 05/24/2012 reported the claimant had a BDI-II score of 25 and BAI score of 23. An Initial Medical Report from Dr. on 05/24/2012 reported that the claimant had ongoing back and left shoulder pain. A pre-authorization request dated 06/01/2012 and signed by Dr., reported the claimant was being recommended for 80 hours of a Chronic Pain Management Program.

A Peer Review from Dr. on 06/07/2012 reported that future treatment should include MRI of the left shoulder.

An Adverse Determination Letter dated 06/08/2012 and signed by Dr. reported that the request for a Chronic Pain Management Program was denied due to inadequate clinical information. A letter of reconsideration dated 06/08/2012 reported that the claimant had been treated with medications, therapy and physical rehabilitation. The note reported that the claimant was taking Cymbalta and does

not have the pain and stress management skills necessary to adequately function in the presence of constant pain. The claimant was again recommended for a Chronic Pain Management Program. An Adverse Determination Letter dated 06/18/2012 signed by Dr. reported that the request for 80 hours was again non-certified due to concerns of submaximum effort on the Functional Capacity Evaluation and uncertainty of prior individual psychotherapy sessions. A letter from Dr. on 06/27/2012 reported that the claimant required medical services only available in a Chronic Pain Management Program.

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

The requested 80 hours of the Chronic Pain Management Program are not necessary. The documentation submitted for review indicates the claimant has been previously treated with physical therapy, chiropractic care, 1 injection and medication management. The 2 prior denials indicated that the basis was partially due to submaximum effort on the Functional Capacity Examination. The appeal letters did not address this concern. There is no indication that the claimant has undergone individual psychotherapy for depressive symptoms. **Official Disability Guidelines** state that there should be an absence of other options likely to result in significant clinical improvement. It does not appear that the claimant has exhausted all lower levels of care at this time.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
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](#).