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Notice of Independent Review Decision

DATE OF REVIEW: 8/15/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 97799 Chronic Pain Management Program 5x wk x 2wks; 80 hours.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of 97799 Chronic Pain Management Program 5x wk x 2wks; 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on the job x/xx/xx when a pallet of bleach fell on top of him. He was seen at the xxxx xxxx complaining of pain in the neck, lower back and shoulders. Diagnostic imaging studies (X-rays of the lumbar spine, left shoulder, and right shoulder and CT scan of the cervical spine without contrast) were reported to be negative. The diagnosis was cervical sprain, shoulder contusion, and back strain.

The worker received therapy. He was seen at the xxxx for follow-up and continuing care. Physical therapy was completed on or before 05/10/2011, when the worker was seen for an outpatient follow-up visit. According to subsequent clinical records the neck and shoulder pain improved but lower back pain and left lower extremity pain persisted. The worker was referred to Dr. for pain management evaluation and treatment.

Dr. reviewed the MRI scan, which was reported to show mild spondylosis mostly at the L4-L5 region. He recommended authorization for lumbar epidural steroid injections. Injections were not authorized. A TENS unit was requested and authorized. On the follow-up visit 07/12/2011 the worker reported that he had been rear-ended by a truck and was seen in the emergency room. Dr. recommended continuing the conservative treatment and provided prescriptions for Norco and Robaxin. A prescription was written for return to work with restrictions, with maximum lifting limit of 15 pounds. Dr. initiated treatment with a prednisone dose pack and requested left sacroiliac injection. Sacroiliac injection was not authorized.

Because of persistence of the lower back and left lower extremity pain, neurosurgery consultation was requested 11/02/2011. No records were submitted regarding whether or not the neurosurgery consultation was authorized or was obtained. Because of the persistence of lower back pain and left lower extremity pain Dr. recommended a chronic pain management program.

On 03/05/2012 worker was seen for an Initial Interview, conducted by MA, LPC-S. According to the report the worker had high scores of 49 on the Beck Depression inventory II, 48 on the Beck anxiety inventory, and a 56 on the SOAPP-R screen. He had high scores on the Fear Avoidance Beliefs Questionnaire (FAB Q). Ten sessions of multidisciplinary chronic pain management were recommended.

A Functional Capacity Evaluation was performed 06/14/2012, wherein the injured worker performed at the minimum physical demand level.

The requested chronic pain management program was non-authorized on 06/25/2012.

An interview dated 06/14/2012 was conducted by MA, LPC-S. Results of the Beck Depression inventory II, Beck anxiety Inventory, the SOAPP-R screen and the Fear Avoidance Beliefs Questionnaire (FAB Q) were reported. Again a program of multidisciplinary pain management was recommended. A plan of treatment was included in the report. On reconsideration the requested treatment program was non-authorized 07/17/2012.

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

Recommended approval of the requested services.

First: The worker meets the criteria for a chronic pain management program.

According to the ODG Guidelines Procedure Summary pertaining to chronic pain management, Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances [the additional statements listed within brackets were derived from the medical records reviewed.

- **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: [the worker continues to rely on Dr. xxxxxx and the treating doctors as a primary means of pain relief].

(b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain: [this was demonstrated on FCE and the questionnaires 06/14/2012].

(c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts: [According to the interviewer the worker has avoided engaging in recreational or social activities].

(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: [the worker currently does not meet employer's physical demand requirements as noted on the functional assessment].

(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): [Self-reported depression and anxiety along with fears of functioning and problems with sleeping habits were documented].

(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: [The worker continues to rely on prescribed narcotic pain medication as his primary means of pain relief. Moreover, according to the SOAPP assessment score, the worker demonstrated a high risk for abuse of prescribed narcotic pain medications, reported in the Interview of 3/05/2012].

- **Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement:** [taking into account those proposed treatment options which were non-authorized, no additional treatment procedures are pending].
- **An adequate and thorough multidisciplinary evaluation has been made...:** [Although no record of a neurosurgery consultation was submitted for this review, the summary of treatments in the 06/14/2012 documents includes the note that no surgical treatment was not recommended].
- **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.**
- **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.

- **Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed:** [A treatment plan was submitted in the clinical record dated 06/14/2012].
- **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.** [These factors were briefly covered in the plan of treatment dated 06/14/2012].
- **Negative predictors of success ... should be identified, and if present, the pre-program goals should indicate how these will be addressed.** [This was briefly addressed in the report from the interview of 06/14/2012,]. **High levels of psychosocial distress. Increased duration of pre-referral disability time. Elevated pre-treatment levels of pain.**
- **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.**
- **Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.** [Request is for two week (10 day) trial].
- **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.**
- **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). 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).**
- **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).**
- **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.

- **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.**

Second, the worker has not had the opportunity to participate in a structured chronic pain management program.

According to the ODG *Integrated Treatment/Disability Duration Guidelines for Pain (Chronic)*

In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the "sickness" role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors.

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 KNOWLEDGBASE
- 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)