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Notice of Independent Review Decision

DATE OF REVIEW: 2/22/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 additional hours of a chronic pain management program for the left ankle at as requested by

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

80 additional hours of a chronic pain management program for the left ankle is not reasonable or medically necessary.

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:

PATIENT CLINICAL HISTORY:

The injured worker is a female who sustained an injury on xx/xx/xx when she xxxx, twisting her left ankle. The Injured worker was seen for behavioral medicine consultation on 05/06/11. The injured worker complaints of ankle pain rating 9 out of 10. Mental status exam revealed the speech was normal, but soft. The mood was dysthymic and anxious with a constricted affect. There was no evidence of

hallucination. The injured worker's BDI score was 6, indicating minimal depression. The injured worker's BAI score was 12, indicating minimal anxiety. She was assessed with pain disorder associated with both psychological factors and a general medical condition. The injured worker was referred for psychotropic medication consultation and was seen for psychological assessment on 10/26/11: medications included Naprosyn, Tramadol, and Citalopram. The injured worker complained of left ankle pain rating 8 out of 10. Mental status exam revealed a dysthymic mood with an appropriate affect. The speech was normal but soft. The injured worker's BDI score was 47, indicating severe depression. Her BAI score was 26, indicating severe anxiety. She was assessed with pain disorder associated with both psychological factors and a general medical condition. The injured worker was recommended for participation in an interdisciplinary chronic pain management program.

A physical performance evaluation performed 11/09/11 placed the injured worker in the light physical demand level while her occupation required a medium physical demand level. She was seen for evaluation on 12/16/11: medications included citalopram, Mobic, and Tramadol. The injured worker complained of left ankle pain rating 9 out of 10. Her BDI score was 25, indicating moderate depression. Her BAI score was 38, indicating severe anxiety, and her Oswestry Disability Index was 38%. The injured worker was recommended for 80 hours of chronic pain management. A physical performance evaluation performed 01/03/12 placed the injured worker in the sedentary physical demand level while her occupation required a medium physical demand level. She was seen for evaluation on 01/06/12: medications included Citalopram, Mobic, and Tramadol. The injured worker complained of left ankle pain rating 8 out of 10. Her BDI score was 40, indicating severe depression. Her BAI score was 29, indicating severe anxiety. Oswestry Disability Index was 50%. Mental status exam revealed a dysthymic mood with appropriate affect. The thought process was goal-directed. The injured worker was assessed with pain disorder associated with both psychological factors and a general medical condition, and was recommended for 80 additional hours of chronic pain management.

The request for 80 hours of additional chronic pain management was denied by utilization review on 01/19/12 due to significant worsening of the BDI score, physical demand level, and Oswestry Disability Score. The request for 80 hours of additional chronic pain management was denied by utilization review on 01/31/12 due to substantial increases with depression and catastrophizing. There was no justification for continuation of the chronic pain management program with important aspects of the claimant's adjustment worsening. There was no clear treatment plan about how to address the psychological factors. The request for 80 hours of additional chronic pain management was denied by utilization review on 02/08/12 as treatment is not suggested for longer periods without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. There was no documentation of any other specific factors to support the request.

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

The requested 80 hours of additional chronic pain management program are not recommended as medically necessary based on current evidence based guideline recommendations. The injured worker has completed an initial chronic pain management program and the clinical documentation demonstrates no significant improvement in the injured worker's psychological scores, ODI, or functional ability. The clinical documentation shows the psychological scores indicate severe depression and anxiety and the injured worker is still at a sedentary physical demand level. Current evidence based guidelines recommend additional chronic pain management program when there is objective evidence of the efficacy of the program for the Worker. As there is no indication from the clinical records that the initial chronic pain management program was beneficial for the injured worker's psychological symptoms or functional level, and additional chronic pain management sessions would not be reasonable and necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines, Online Version, 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).

(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).