

# CASEREVIEW

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## Notice of Independent Review Decision

**DATE OF REVIEW:** January 20, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management Program Add'l 80Hrs Lumbar - 97799

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

**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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

04/02/07 – 04/06/07: Chronic Pain Daily Progress Notes/Group Therapy Notes/Chronic Pain Daily Flow Sheets from Injury 1 Treatment Center

04/09/07: Chronic Pain Management Program Preauthorization Request by Injury 1 Treatment Center.

05/17/07: IRO Decision regarding Chronic Pain Management Program

04/09/08: Designated Doctor Report of Medical Evaluation by DO

12/22/10: Office Visit at Austin Pain Associates with Pa-C for MD  
03/23/11: Office Visit at Austin Pain Associates with Pa-C for MD  
07/13/11: History and Physical by MD  
07/14/11: Assessment/Evaluation for Chronic Pain Management Program at Injury 1 of  
by MS, CRC, LPC and MS, LPC intern  
07/14/11: Functional Abilities Evaluation at US Evaluation Center  
08/24/11: History and Physical for Chronic Pain Management Program by MD  
10/03/11: Request for 80hrs of a Chronic Pain Management Program from Injury 1  
10/11/11, 10/25/11, 10/27/11, 10/28/11, 11/03/11, 11/04/11: Chronic Pain Management  
Program Daily Progress Notes/Group Psychotherapy Notes/Individual Patient  
Coordination/Patient Activity Flow Sheets/Daily Rehabilitation Worksheets from Injury 1  
10/28/11: Reassessment for Chronic Pain Management Program Continuation from  
Injury 1 by MS, CRC, LPC  
11/01/11: Physical Performance Evaluation at KDT Center by DC  
11/21/11: Request for 80 hours of a Chronic Pain Management Program from Injury 1  
of Waco  
11/28/11: UR performed by MD  
12/12/11: Reconsideration: Request for Chronic Pain Management Program from Injury  
1 by PsyD and PhD  
12/20/11: UR performed by PhD

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx while he was placing tanks underneath an RV and he went to pick up the tank with his right arm and the tank slipped, falling on his right leg. He noted he felt a pop and an immediate onset of severe pain in his lower back when he twisted to catch the tank. A MRI of the Lumbar spine on October 13, 2005 revealed a right paracentral disc protrusion, L5-S1. He received treatment in the form of chiropractic manipulation, physical therapy, work hardening, massage and epidural steroid injection.

On April 9, 2007, there was a Chronic Pain Management Program Preauthorization Request by Injury 1 Treatment Center. It was noted that an initial 10 day trial of the interdisciplinary pain rehabilitation program had been deemed medically necessary and the claimant had completed the preauthorized days with maximal effort. At the end of the 10 days, his PDL was listed as Light-Medium with a required PDL of Medium.

On May 17, 2007, there was an IRO Decision regarding Chronic Pain Management Program in which the denial of the program was upheld. The Reviewer opined that there had been minimal change in the symptoms and the patient had previously had extensive physical therapy. The patient's psych status had not changed significantly. Per ACOEM Guidelines 2004, a program should be continued only if there is evidence of function gains.

On April 9, 2008, the claimant was evaluation by DO, a designated doctor. Dr. opined that the claimant had obtained statutory MMI as of October 4, 2007 with a 5% whole person impairment.

On December 22, 2010, the claimant had a follow-up evaluation at Pain Associates with Pa-C for MD. Diagnosis: Lumbar sprain/strain, lumbar/thoracic radiculitis, and medication management high risk medications. Plan: Decrease Lyrica to 75 mg and continuation of home exercise program.

On July 13, 2011, the claimant was evaluated by MD. On physical examination of his back, flexion was 50 degrees and extension was 5 degrees. Straight leg raise test was negative and bilateral knee reflexes were weak. Impression: Lumbar sprain, history of right radiculopathy L5-S1, and associated depression and anxiety. Plan: Referral for an FCE.

On July 14, 2011, there was an Assessment/Evaluation for Chronic Pain Management Program from Injury 1 by MS, CRC, LPC and MS, LPC intern. It was noted the claimant had previously completed 6 of 6 days of IPT sessions with good benefits.

On July 14, 2011, the claimant underwent a Functional Abilities Evaluation. Recommendations: It is my opinion that this patient does not meet the requirements, safety, or performance ability to do the job safely, effectively, or confidently (without restrictions). The patient is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment. The patient should continue care with their treating doctor in order to help the patient's condition, minimize and correct as well as reduce muscle spasms, decrease joint adhesions, increase range of motion, and decrease the perception of pain. A psychological evaluation for the patient's emotional complications as a result of their injury and the surrounding problems with being off work which includes but is not limited to the possibility of depression and a lack of self worth. Multidisciplinary chronic pain management program to further address mental and psychological issues that are complicating patient's progress in their treatment program and ultimately their return to gainful employment.

On October 3, 2011, there was a Request for 80hrs of a Chronic Pain Management Program from Injury 1. It was noted his injury relate medication was Hydrocodone-acetaminophen 5-500 mg bid and Lyrica 75 mg qd. Titration of Hydrocodone and Lyrica would be a focus of the program. It was reported that the claimant described his pain as chronic, persistent, and intractable at 5-8/10, depending on his level of activity. His current PDL was listed at Light based on the FCE completed on 07/14/11.

On October 28, 2011, there was a Reassessment for Chronic Pain Management Program Continuation from Injury 1 by MS, CRC, LPC.

On November 1, 2011, the claimant underwent a Physical Performance. Based on the results, the claimant was listed to be in the Light to Medium PDL. Assessments: The evaluatee has made objective improvements in the following areas since last evaluation: static strength, EPIC lifting, functional specific testing, and NIOSH. The evaluatee is unable to perform their regular job duties at this time. The evaluatee cannot safely

perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: A psychological evaluation for the evaluatee's emotional complications as a result of their injury. Continued participation in the multidisciplinary Chronic Pain Management program.

On November 21, 2011, there was a Request for 80 hours of a Chronic Pain Management Program from Injury 1 of Waco. It was noted that the claimant was able to report reductions in pain, irritability, frustration, muscle tension spasm, anxiety, sleep disturbance, forgetfulness, and BDI-II depression score. However, his depression had increased. It was reported that the claimant continued to demonstrate functional deficits, marked pain, and sleep disturbance that were impacting his ability to safely return to work. It was reported that the program had exerted some positive impact on the claimant's symptoms; however, he had not met the targeted reduction of 75% in every active symptom. His current PDL was listed as Light-Medium. It was stated that based on progress made within 80 hours of the program, the claimant's treating doctor has prescribed continued participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this claimant's pain experience, develop self-regulation skills, facilitate a timely return to the work force, and obtain medical case closure.

On November 28, 2011, MD performed a UR on the claimant. Rationale for Denial: Eighty hours of Chronic Pain Management was authorized on 10/07/11, as per UR nurse's clinical summary. Progress notes were submitted and showed functional improvement. However, it is noted that pre-IPRP was Light-Medium and current PDL was still at a Light-Medium. Furthermore, it is noted that the patient has already attended nine Chronic Pain Management sessions, as per medical dated "040507." Per the referenced guidelines, 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). Therefore, the medical necessity of this request cannot be established at this point.

On December 12, 2011, there was a Reconsideration Request for Chronic Pain Management Program from Injury 1 by, PsyD and PhD. Response to the denial: After researching records he did complete 9 days of CPM back in April 2007 under Shawn Fyke, DC. It looks like we also requested a continuation of the program, but that was denied. In 2009 he completed 6 individual therapy sessions, then surgery was recommended but he declined, then complete psychological testing in 2011, and he recently completed 10 days of CPM recently. Despite him still being at a Light-Medium PDL, he still made gains. He is close to reaching a Medium PDL. Given that Duster Camper has closed down he has to return to work in a different position with a different employer. For the next 10 days, patient will work on developing his resume and researching 3 new employers in the surrounding area and practice mock interviews with clinician. The goal is for him to reach a Medium PDL so he can have more viable job options.

On December 20, 2011, PhD performed a UR on the claimant. Rationale for Denial: The request for chronic pain management program additional 80 hours is not recommended as medically necessary. Per telephonic consultation with Dr., the patient has had 19 total sessions of chronic pain management program, 9 sessions in 2007 and 10 recent sessions. The patient has shown some improvement, but he elected not to return in 2007 to complete the program. Given the current clinical data, the request chronic pain management program x 80 hours is non-certified.

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

Denial of additional 80 hrs of Chronic Pain Management Program is upheld/agreed upon. Per ODG Pain Chapter #13) "At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar 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)." The claimant attended CPM in 2007 and, furthermore, after more recent attendance in CPM, the claimant has not demonstrated functional gains-remaining at the same Light-Medium PDL.

**ODG:**

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "[Delayed recovery](#)." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. ([Flor, 1992](#)) ([Gallagher, 1999](#)) ([Guzman, 2001](#)) ([Gross, 2005](#)) ([Sullivan, 2005](#)) ([Dysvik, 2005](#)) ([Airaksinen, 2006](#)) ([Schonstein, 2003](#)) ([Sanders, 2005](#)) ([Patrick, 2004](#)) ([Buchner, 2006](#)) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. ([Gatchel, 2005](#)) See [Biopsychosocial model of chronic pain](#).

**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)**