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Notice of Independent Review Decision

Date notice sent to all parties:

July 2, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Program, per hour.

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 determinations should be: Upheld

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. 05/11/2012—Clinical note—PhD.
2. 05/15/2012—Required Medical Examination—MD.
3. 05/16/2012—Physical Performance Evaluation—DC.
4. 05/23/2012—Request for additional treatment—No signature.
5. 05/29/2012—Adverse determination letter—MD.
6. 05/31/2012—Reconsideration letter—PsyD, LPC.
7. 06/07/2012—Adverse determination letter—PsyD.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. Clinical note dated 05/11/2012 reported the patient had participated in 5 days of pain program. The note reported the patient had decreased pain from 8/10 to 7/10. The note reported the patient's BAI score had increased from 24 to 32 and BDI had increased from 26 to 46. The note reported the patient appeared frustrated about difficulty completing test tasks. The patient was recommended to continue participation in the neural cognitive behavioral program. Required Medical Examination from Dr. on 05/15/2012 reported that 30 to 50 sessions of neuropsychiatric treatment concurrent with neuropsychiatric medications and return to work plan would be reasonable and medically necessary. Physical Performance Evaluation dated 05/16/2012 reported the patient required a heavy physical demand level. Testing revealed that the patient was able to lift 30 to 35 pounds occasionally and 15 pounds frequently. Request for 80 additional hours of a cognitive rehabilitation program dated 05/23/2012 reported the patient had completed 40 hours. The note reported the patient was initially injured when he fell off a platform approximately 20 feet high, landing head-first on a cement ground. The note reported the patient lost consciousness and was taken to the emergency room. The patient was noted to have been previously treated with medication and 6 sessions of individual psychotherapy. The patient reported past symptoms to include pain, headaches, nausea, difficulty swallowing, blurred vision, difficulty hearing of the right side, disorientation and confusion, balance problems, staring spells, and memory impairment. The patient was noted to have subjectively decreased pain from 8/10 to 7/10, anxiety from 8/10 to 6/10, and depression from 7/10 to 6/10. The note reported the patient was at a medium physical demand level and required a heavy physical demand level. The patient was recommended for additional treatment. Adverse determination letter dated 05/29/2012 from Dr. reported the request was denied, as the patient was already at the physical demand level required by the job of medium. The report also indicated that per peer-to-peer with Dr., he stated that the program was not examining the patient's progress in a way that makes sense and that different measures were needed. Letter of reconsideration dated 05/31/2012 reported that the patient did not require a medium PDL, but required a heavy PDL. The note also reported that patients are assessed with NEUROPSI, VAS—Neurocognitive symptoms ratings scales, Beck Depression Inventory, Beck Anxiety Inventory, and PSRS. The patient was again recommended for additional treatment. Adverse determination letter dated 06/07/2012 from Dr. reported the request was denied due to lack of adequate documentation of appropriate interventions consistent with Official Disability Guidelines for cognitive rehabilitation. The note reported peer-to-peer with Dr. agreed that the documentation submitted and acknowledged that it was unclear if there had been appropriate intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL

BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for 80 additional hours of chronic pain program is non-certified. The documentation submitted for review indicates the patient has participated in 40 hours of a neural cognitive behavioral program with limited improvement. The documentation submitted for review did not contain a pre-program psychological evaluation or physical performance evaluation. The documentation submitted for review fails to indicate the patient has made any significant objective functional progress with current treatment. The patient's Beck Depression Inventory and Beck Anxiety Inventory scores have increased with recent treatment. There is no indication that the patient has increased physical demand level or decreased medications with prior treatment in accordance with **Official Disability Guidelines**. The request has been deemed not medically necessary twice previously with apparent agreement with the peer-to-peer reviewer. The documentation submitted for review did not address the concerns discussed in the 2 previous non-certifications. Therefore, this reviewer agrees that the request for 80 additional hours is non-certified.

IRO REVIEWER REPORT TEMPLATE -WC

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

Reference: Official Disability Guidelines, Pain Chapter, Online Version

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](#).