



**MEDICAL EVALUATORS
OF T E X A S** ASO, L.L.C.

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

June 22, 2012

Amendment Date: June 28, 2012

DATE OF REVIEW: June 22, 2012

AMENDMENT DATE: JUNE 28, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program – 80 hours/units - initial

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

The reviewer of this case is one that is licensed in Texas with a specialty of Psychology.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
An employer's first report of injury or illness	Xx/xx/xx
X-ray of the lumbar spine	04/08/2010
X-ray of the thoracic spine	04/08/2010
X-ray of the left knee	04/08/2010
MRI of the lumbar spine	04/23/2010
MRI of the thoracic spine	04/23/2010
MRI of the left knee	05/19/2010



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A medical report from DO	06/02/2010
EMG/NCS of lower extremities by MD	06/04/2010
A report of medical evaluation by MD	06/09/2010
A DWC-69 by MD	06/09/2010
An office note by MD	06/23/2010
An operative report by MD	07/02/2010
A follow up report from DO	07/07/2010
An office note by MD	07/14/2010
A follow up report from DO	08/14/2010
A follow up report from DO	09/08/2010
A follow up report from DO	10/06/2010
An office note by MD	10/11/2010
A follow up report from DO	11/01/2010
A DDE by MD	11/04/2010
A DWC-69 by MD	11/04/2010
An office note by MD	11/08/2010
A review of DDE by DO	11/15/2010
Impairment rating review from MD	11/17/2010
A follow up report from DO	12/06/2010
An office note by MD	12/06/2010
MRI of the left knee	12/14/2010
A letter from MD	12/20/2010
A follow up report from DO	12/20/2010
An office note by MD	12/22/2010
An operative report by MD	12/31/2010
A follow up report from DO	01/11/2011
A follow up report from DO	02/08/2011
A follow up report from DO	03/07/2011
An office note by MD	03/22/2011
A follow up report from DO	04/04/2011
An office note by MD	04/19/2011
Notice of disputed issues and refusal to pay benefits from Claims Admin	04/20/2011
An office note by MD	05/24/2011
An office note by MD	06/21/2011
FCE from Evaluation Center	06/21/2011
A follow up report from DO	06/27/2011
An IRO by Board certified in Anesthesiology and Pain Management	06/30/2011
A follow up report from DO	07/25/2011
An initial behavioral Medicine Consultation by, LBSW-IPR/ LCSW	07/28/2011



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An assessment for WHP by PhD	07/28/2011
A preauthorization request from Injury 1 of	08/04/2011
A reconsideration for preauthorization request from Injury 1 of	08/17/2011
An office note by MD	08/31/2011
A follow up report from DO	09/19/2011
An office note by MD	09/26/2011
FCE from Center	10/10/2011
A follow up report from DO	10/17/2011
A follow up report from DO	10/31/2011
A pain clinic consultation from Pain Medicine	11/11/2011
A follow up report from DO	12/05/2011
A follow up report from DO	01/04/2012
PPE from Center	01/13/2012
Behavioral medicine reassessment by LBSW-IPR/, LCSW	01/25/2012
A follow up report from DO	03/05/2012
A DWC-73 from DO	03/05/2012
An individual psychotherapy note from, LBSW-IPR/, LCSW	03/09/2012
PPE from KDT Center	03/12/2012
An individual psychotherapy note from, LBSW-IPR/, LCSW	03/16/2012
An individual psychotherapy note from, LBSW-IPR/, LCSW	04/09/2012
Assessment/evaluation for CPMP from, LBSW-IPR/, LCSW	04/16/2012
A psychological assessment report from PsyD	04/30/2012
A follow up report from DO	05/01/2012
A DWC-73 from DO	05/01/2012
A request for 80 hours/units of CPMP from Injury 1 of by, PsyD, LPC	05/14/2012
A notice of denial from Comprehensive Solutions, Inc.	05/17/2012
A reconsideration for 80 hours/units of CPMP from Injury 1 of by, PsyD, LPC	05/22/2012
A notice of denial from Comprehensive Solutions, Inc.	05/31/2012



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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who works for as a who sustained work-related injuries on xx/xx/xx. She was reaching over and cleaning tables in the gym at school when she felt pain in her mid back, lower back and left knee area. She had x-rays and MRI done and was evaluated and treated by Dr.. She subsequently saw Dr. who performed left knee surgeries x2 on 07/02/2010 and 12/31/2010. She was seen by Dr. on 12/20/2010 at which time she complained of pain in lower back with radiation to right lower extremity at a non-dermatomal distribution and stated she is not a surgical candidate. She was then seen by Dr. who recommended work hardening program. On 04/30/2012, she was seen by Dr. who recommended chronic pain management program which is denied.

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

The claimant appears to have been conservatively and surgically treated, but continues to have a delay in full recovery. There are times in medical record where “Work Hardening Program” and “Chronic Pain Management Program (CPMP)” are used interchangeably but they are two different programs. The claimant has been denied at IRO level for a work hardening program and now the request is for 80 hours of CPMP. It appears from medical records that the claimant did have some psychotherapy that was deemed not that useful. However, there were no records of the notes concerning the psychotherapy. Medical record also states that the claimant has had work hardening, so this is confusing. A full psychological evaluation by a psychologist was not completed; there was no testing of characterological factors. A statement of “Mrs. has not been diagnosed with a personality disorder or psychological condition without a physical component” is not sufficient. Original injury date is over two years old, the ODG is clear in stating 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. There is no indication that the claimant will have some specialized treatment in the CPMP because of her delay in entering such program. Given the information received in medical records, past reviews, and the ODG criteria, I am agreeing with past reviews and the adverse determination is upheld.

ODG INDICATION FOR CHRONIC PAIN PROGRAM:

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



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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.



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(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.



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(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.



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**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)