

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE OF REVIEW: March 6, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program, 80 hours/10 visits, CPT code 97799 for the right knee, bilateral arms, low back, right shoulder, ribs.

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 18 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:

09/13/11: Initial Behavioral Medicine Consultation at by
09/15/11: Report of Medical Evaluation by designated doctor
10/03/11: Work Hardening Daily Note from
10/03/11: Group Psychotherapy Note from
10/03/11: Daily Rehabilitation Worksheet from
10/17/11: Work Hardening Daily Note from
10/17/11: Group Psychotherapy Note from
10/17/11: Daily Rehabilitation Worksheet from
12/20/11: Individual psychotherapy Treatment Re-assessment Summary & Request for Additional Services from
01/03/12: Physical Performance Evaluation
01/04/12: Clinic Note from Texas Medical Institute by
01/06/12: Psychological Assessment Report from by

01/19/12: Request for Initial 80 Hours/Units of a Chronic Pain Management Program from

01/24/12: UR performed by

02/02/12: Reconsideration: Chronic Pain Program x 10Days/Sessions (5x2weeks) from by

02/07/12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the claimant, a male, sustained injuries to his head/face, ribs, right shoulder, bilateral forearms, right knee, and low back when he fell. The claimant endorsed the following symptoms indicative of head trauma to include: visual problems, memory problems, confusion, and dizziness/balance problems. He has undergone arthroscopic surgery on his right shoulder and right knee and participated in physical therapy.

09/13/11: The claimant had an Initial Behavioral Medicine Consultation with at the directive of his treating doctor. The claimant's pain was reported as being 5/10 on a daily average with intermittent elevations of 8/10. It was reported that he was currently off work, but still in contact with his employer. The claimant was reported to be eager to return to work in his same position. The claimant reported difficulty with acts of daily living to include: self-grooming, household chores, yard work, exercise/playing sports, driving 1-2 hours, sitting 1 hour, standing 1 hour, walking 1 hour, bending, squatting, lifting/carrying items in excess of 10 pounds, and climbing stairs. He reported changes in relationships to include: more conflict with family, less involved in family activities, isolate from others, less participation in social outings, and feeling abandoned by co-workers. He endorsed both initial and sleep maintenance insomnia. Overall he reports a current level of functioning of 50%. The claimant scored a 16 on the BDI-II, indicating mild depression. His score on the BAI was 24, reflecting moderate anxiety. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) did reveal significant fear avoidance of physical activity in general (FABQ-PA = 24), as well as significant fear avoidance of work (FABQ-W = 42). Multiaxial diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition. Axis II: no diagnosis. Axis III: Injury to head/face, ribs (right), right shoulder, bilateral forearms, right knee, and low back. Axis IV: Primary support group, social environment, occupational problems, access to health care problems, and other psychosocial and environmental problems. Axis V: GAF: current 43; Estimate pre-injury: 75+. Recommendation: Given the information gathered in this intake, the patient would be an excellent candidate for the Work Hardening Program and his psychosocial problems may be effectively addressed in didactic group therapy services offered in this program.

12/20/11: The claimant had an individual psychotherapy treatment re-assessment which indicated on his Multiaxial Diagnosis that his GAF: current increased to 55. Current medications were listed as Voltaren Gel 100 mg, Ultram ER 200 mg, Elavil 25 mg, and Cymbalta 20 mg. It was reported the claimant completed 6 of 6 authorized sessions of Individual Psychotherapy and despite his unrelenting pain and protracted treatment; he had been responsive to treatment and benefitted from the limited IPT.

Post IPT his FABQ-W = 42 (remaining the same) and FABQ-PA = 15 (decreased from 24). His BDI-II score increased to 27, reflecting moderate depression and his BAI decreased to 26 reflecting severe anxiety. Recommendations: Conservative treatment had been exhausted and the claimant was recommended for treatment in a tertiary CPM program, which would assist him to reduce his negative work injury symptoms, continue addressing his psychological needs more effectively, while also assisting with vocational planning, pain management with decrease use of pain medication, and providing assistance with improved physical functioning to help his realize treatment objectives, facilitate a safe return to work, and appropriate medical case closure.

01/03/12: The claimant underwent a Physical Performance Evaluation. His job description was classified in the Medium PDL and the claimant tested in the Light PDL.

01/06/12: The claimant had a Psychological Assessment by at the directive of his treating doctor. The claimant's pain was reported as being 5/10 on a daily average with intermittent elevations of 8/10. The claimant reported difficulty with acts of daily living to include: self-grooming, household chores, yard work, exercise/playing sports, driving 1-2 hours, sitting 1 hour, standing 1 hour, walking 1 hour, bending, squatting, lifting/carrying items in excess of 10 pounds, and climbing stairs. He reported changes in relationships to include: more conflict with family, less involved in family activities, isolate from others, less participation in social outings, and feeling abandoned by co-workers. He endorsed both initial and sleep maintenance insomnia. The claimant scored a 25 on the BDI-II, indicating moderate depression. His score on the BAI was 21, reflecting moderate anxiety. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) did reveal significant fear avoidance of physical activity in general (FABQ-PA = 24), as well as significant fear avoidance of work (FABQ-W = 42). Multiaxial diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition. Axis II: no diagnosis. Axis III: Injury to head/face, ribs (right), right shoulder, bilateral forearms, right knee, and low back. Axis IV: Primary support group, social environment, occupational problems, access to health care problems, legal issues, psychosocial and environmental problems. Axis V: GAF: current 59; Estimate pre-injury: 75+. Recommendation: At this time, conservative treatment has been exhausted and is recommended for treatment in a tertiary CPM program.

01/19/12: A Request for Initial 80 Hours/Units of a Chronic Pain Management Program documented: describes his pain as chronic, persistent, and intractable at 5/10 with intermittent elevations of 7/10. He was able to report reductions in frustration, anxiety, depression, and sleep disturbance. He notes maintenance of function in pain, irritability, and muscle tension/spasm. He reports increases in forgetfulness and BDI-II depression score. Clearly, symptoms have proven refractory to conservative levels of care and he has subsequently developed a chronic pain syndrome. continues to demonstrate functional deficits, marked pain, and sleep disturbance that are impacting his ability to safely return to work. requires as a medical necessity a more intensive, interdisciplinary pain rehabilitation program in order to resolve active symptoms on a long term basis, dismantle his disabled self-perception, increase his functional tolerances, and propel

this patient toward a safe return to work. It was noted that the claimant plans to return to the same employer in the same position once he has reached the ability to work without restrictions.

01/24/12: UR performed by. Rationale for Denial: In this case, there has been a course of work hardening for this patient and a clear rationale for another multidisciplinary program following a previous program has not been documented. It has only been stated that the guidelines would not preclude the patient from another program. However, based on the available information, medical necessity is not established for this request and an adverse determination is recommended.

02/02/12: A Reconsideration letter indicated in response to the adverse determination that the claimant had exhausted low level of care including arthroscopic surgery of his right shoulder and right knee, physical therapy, 10 days in Work Hardening Program where he was discharged due to his psychological distress and placed in 6 sessions of individual psychotherapy. It was also once again noted that based on the FCE performed on 01/03/12, the claimant tested in the Light PDL and his required PDL is Medium.

02/07/12: UR performed by. Rationale for Denial: The patient has completed all relevant medical care, up to and including surgery and a work hardening program. Despite this care, he continues to report refractory pain and psychosocial problems related to pain. However, the guidelines state, "At the conclusion and subsequently, neither re-enrollment in or 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)." As this patient has completed a work hardening program previously, this request for chronic pain management program, 80 hours/10 visits, CPT code 97799 for the right knee, bilateral arms, low back, right shoulder, ribs is not medically reasonable or necessary.

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

The prior adverse determinations are upheld. The request for chronic pain management program, 80 hours/10 visits, CPT code 97799 for the right knee, bilateral arms, low back, right shoulder, ribs does not meet ODG criteria #3(a). There was no documentation submitted for review that had a physical examination that ruled out conditions that require treatment prior to initiating the program. Only a PPE outlining his physical capabilities and deficits was submitted for review, not an actual physical exam performed by his primary treating doctor. The request also does not meet ODG criteria #7; there was no documentation of the claimant's motivation to change or willingness to change his medication regimen. There have also been questions raised regarding criteria #13. ODG does state that "prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated." The claimant participated in 10 days of a Work Hardening Program where he was discharged due to his psychological distress and

then placed in 6 sessions of individual psychotherapy which he completed. Following the individual psychotherapy a re-assessment was performed on 12/20/11 in which it was recorded that his FABQ-W = 42 following IPT, where as it was down to 36 following Work Hardening. His score was FABQ-PA = 15 following IPT, but had been down to 12 following Work Hardening. His BDI-II score also increased from 21 following Work Hardening to 27 following IPT and his BAI score increased from 17 following Work Hardening to 26 following IPT. With the lack of improvement following IPT and Work Hardening and the lack of documentation verifying that ODG criteria #3(a) and #7 have been met, I find the request for chronic pain management program, 80 hours/10 visits, CPT code 97799 for the right knee, bilateral arms, low back, right shoulder, ribs is not medically supported.

ODG:

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)**