

Independent Reviewers of Texas
4100 West Eldorado Pkwy #100-373
McKinney TX 75070
independentreviewers@hotmail.com
Phone: 469-218-1010
Fax#: 469-374-5862

Notice of Independent Review Decision

DATE OF REVIEW: 03/02/2012

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: requests reconsideration of the 1/27/11 denial of pre-authorization of chronic pain management program 5 times per week for 2 weeks for chronic left shoulder pain; outpatient.

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 determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request for 10 sessions of chronic pain management program note dated 01/18/2012, by residual functional capacity battery dated 01/23/2012, by clinical note dated 01/25/2012, by notice of deny of pre-authorization dated 01/27/2012, clinical note dated 02/06/2012, by, notice of reconsideration dated 02/08/2012, and request for medical dispute resolution dated 02/20/2012, by

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female with a reported injury on xx/xx/xx. The request for 10 sessions of chronic pain management program note dated 01/18/2012, revealed the patient was recommended for completion of individual psychotherapy and subsequently to participate in a multidisciplinary chronic pain management program to aid the patient in dealing with depression, anxiety, and pain symptoms associated with both psychological and general medical condition, as well as chronic pain. The note indicated that the patient's individual psychotherapy sessions were insufficient to the patient's needs and was noted to be mildly useful and helpful. It was noted that the

patient continued to verbalize depressed feelings, stress, tension, and pain. It was noted that the patient had a BDI-II score of 23 which was indicative of a severe range of depression and after the completion of the initial individual psychotherapy sessions, had a BDI-II score of 15 which was a moderate to severe range for depression. The patient's BAI score was noted to be a 20 which was the moderate range for anxiety and after completion of individual psychotherapy, was noted to have a BAI score of 14. At that time, the patient was recommended to be in the chronic pain management program. The residual functional capacity battery dated 01/23/2012, revealed that the patient was unable to return to work in any capacity and was not capable of lifting anything, or carrying anything. It was noted that the patient in order to return to work as a nurse assistant needed to meet a medium physical demand level. The peer review dated 02/06/2012, by indicated that the patient's request for a chronic pain management program was non-certified due to the patient was 10 years status post left shoulder arthroscopy. It was noted that the patient had a functional capacity evaluation in which the patient did not do any lifting whatsoever. It was noted the patient had 6-8 sessions of cognitive behavioral therapy, in which the patient did benefit; however, there is no indication that there has been any increase function involving the left shoulder. The clinical note dated 02/20/2012, revealed the patient had exhausted all lower levels of care and was pending no additional procedures. At that time, the patient was recommended to begin 10 days of a chronic pain management program.

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

It is noted that the patient is status post left shoulder arthroscopy and has suffered anxiety, depression and chronic pain symptoms since date of injury. It was noted that prior to initiating the chronic pain management program the patient was recommended for a course of individual psychotherapy, which was found to be mildly helpful. It was noted that the patient decreased her BDI-II and BAI scores during the initial individual psychotherapy sessions; however, continued to have moderate to severe signs of depression and anxiety. The initial non-certification for the chronic pain management program on 01/25/2012, revealed the patient's request was not certified due to the injury being over 10 years old and the patient had not had any recent conservative treatment other than therapy. It was also noted that the patient had multiple psychological issues that needed to be addressed. The second non certification for the chronic pain management program dated 02/06/2012, revealed the patient's request was not approved due to lack of documentation indicating the patient's functional deficits, that the patient has not attempted to return to work since date of injury 10 years prior, and the functional capacity evaluation noted that the patient was unable to push, or pull whatsoever. The **Official Disability Guidelines** state that for a patient to be enrolled in a chronic pain management program there is specific criteria that needs to be met. The documentation provided does not indicate that the patient has had a comprehensive psychological evaluation to not if there is any negative predictors or success. It was noted that the patient has moderate to severe ranges of depression and anxiety in which she has attended 6-8 sessions of previous individual psychotherapy that was found to be mildly helpful. There is also lack of documentation indicating that previous methods of treating chronic pain had been unsuccessful. There is no indication that the patient has had any recent conservative treatments to include physical therapy and a home exercise programs to decrease the pain symptoms. Furthermore, it is noted that

based on the patient's residual functional capacity battery there is lack of documentation indicating the patient's motivation to change and willingness to change prescribed medication regimen in order to return to work. Given the above indications, the previous decisions for non-certification of chronic pain management program 5 times a week x2 weeks for 10 sessions is upheld.

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

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.