



**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 05/21/12

**IRO CASE #:**

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

Chronic Pain Management Program X 80 Hours

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

Clinical psychologist; Member American Academy of Pain Management

**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)

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.

Chronic Pain Management Program X 80 Hours – OVERTURNED

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient is a female who was injured on xx/xx/xx while performing her regular job duties. On the above-mentioned date, patient sustained an injury to her left wrist, which resulted in three surgeries, all judged to be reasonable and necessary and related to

repetitive use. The patient received her first surgery (de Quervain's release) on 03/06/08 from. On 08/04/09, hand surgeon saw the patient and wrote in his notes that "She has had this wrist pain intermittently for over a year. I think that prognosis for...pain...is guarded. However, I do not feel that this changes the underlying facts of the case and that she does have a bony abnormality in the area of pain that was very likely present at the time of her initial diagnosis of the extensor tenosynovitis." He recommended re-exploration of the wrist. On 09/09/09, performed a first dorsal compartment release, excision of radius bone spur, and exploration of radial sensory nerve surgery. On 08/30/11, the patient underwent her third surgery for the compensable injury with which was a repair of injury to the sensory branch of the radial nerve of the left wrist. On 03/05/12, she was given a 3% whole person impairment rating with a recommendation that "the claimant continue with the approved psychotherapy for pain..."

Since the injury, the patient has received the following diagnostics and interventions: x-rays, MRI's (positive), surgery times 3, physical therapy, individual psychotherapy times 4, and medications management. Her current medications include: Gabapentin, Ibuprofen, and Prozac. PPA conducted a pre-program request, with results showing patient performing at a Sedentary physical demand level, with return to work physical demand level being Medium. Her current diagnoses were: left wrist injury, 307.89 Pain Disorder, and 296.22 MDD, single episode, moderate. Recommendation at that time from patient's treating doctor was 80 hours of chronic pain management program, which is the subject of this review.

The current psychometric testing showed MMPI-2 profile was a 2-3/3-2, indicating a depressed mood accompanied by pessimism, worry, physical complaints and extreme fatigue. BHI-2 showed a relatively high level of functional disability and perception of even the mildest pain patient experiences as intolerable. She scored a 17 on the BDI and a 5 on the BAI, post individual therapy. Average daily pain was reported as 3/10, escalating to 7/10 with participation in "normal activities". Mental status examination revealed dysthymic mood and appropriate affect. FABQ-W is 40, and GAF currently was 59 vs. 83+ pre-injury. Vocationally, the patient reported working for her previous employer intermittently, until she was terminated. The current request was for 10 days of a chronic pain management program with goals of increasing her physical, psychosocial, and functional tolerances while decreasing her fear avoidance behaviors so as to facilitate a safe and successful return to work.

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

The patient appears motivated, has a good work history, and has followed all recommendations to date. No signs of malingering are perceived in any of the reports and all surgeries and therapies were approved as reasonable and necessary. Per ODG, a stepped-care approach to treatment has been prescribed, and followed, but patient continues with pain and functional deficits. Goals for the requested 80 hour program are appropriate and should include step-down from A/D meds. Contraindications are limited

and a plan exists to deal with each of them. Patient is s/p 3 surgeries and has not plateaued in her physical and biopsychosocial recovery. She has overall moderate symptoms on average, which matches the request for 80 hours of CPMP. She meets criteria as a chronic pain patient, and as such, request is considered medically necessary and reasonable.

***Criteria for the general use of multidisciplinary pain management programs 2012 Pain Chapter:***

*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 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.*

(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.

*Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. ([WCRI, 2005](#)) ([Joling, 2006](#)) ([PERI, 2005](#)) ([Smith, 2001](#)) ([Stover, 2007](#)) Delayed recovery has been associated with delayed referral to nurse case management. ([Pransky, 2006](#))*

**Cognitive therapy for depression: Recommended.** Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ([Pampallona, 2004](#)) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ([Royal Australian, 2003](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. ([Warren, 2005](#))

**ODG Psychotherapy Guidelines:**

*Initial trial of 6 visits over 6 weeks*

*With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)*

**Psychological treatment:** *Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:*

**Step 1:** *Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.*

**Step 2:** *Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.*

**Step 3:** *Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines for low back problems](#). ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))*

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**