

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** July 29, 2013

**IRO CASE #:**

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

Chronic Pain Management Program 5 x 2 x 80 hours Right Foot/Ankle 97799

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

The reviewer is certified by the American Board of Physical Medicine and Rehabilitation with 16 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 medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

12/09/11: MRI Right Lower Extremity report  
05/23/12: Functional Capacity Evaluation  
09/11/12: Operative Report  
09/17/12: Visit Note Summary  
01/28/13: Report of Medical Evaluation  
03/26/13: Initial Clinical Interview and Assessment  
03/27/13: Visit Note Summary  
04/25/13: Individual Psychotherapy Note  
05/07/13: Assessment/Evaluation for Chronic Pain Management Program  
05/09/13: Functional Capacity Evaluation  
05/09/13: History and Physical  
05/28/13: Psychological Testing and Assessment Report  
06/13/13: Provider/Specialist Referral Form  
06/17/13: Chronic Pain Management Preauthorization Request  
06/20/13: UR performed  
06/28/13: Reconsideration Request  
07/03/13: UR performed

## Patient Face Sheet

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured while he was working on xx/xx/xx.

12/09/11: MRI Right Lower Extremity report. IMPRESSION: There is a focus of magnetic susceptibility artifact within the subcutaneous fat within the medial aspect of the proximal right calf. It is located at the level of the proximal tibial diaphysis. No underlying muscular or bone abnormalities are appreciated.

09/11/12: Operative Report by DPM. POSTOPERATIVE DIAGNOSES: Entrapment of common peroneal nerve of right lower leg. Tarsal tunnel syndrome with entrapment of multiple distal branches of the tibial nerve of the right medial ankle. Entrapment of sural nerve with chronic peroneal tenosynovitis of the right lower lateral ankle. PROCEDURES PERFORMED: External neurolysis of common peroneal nerve of right lower leg. Tarsal tunnel release via decompression of tibial nerve. External neurolysis of medial calcaneal nerve, plantar lateral nerve, and plantar medial nerve of right medial ankle. External neurolysis of sural nerve of right lower lateral ankle and peroneal tenosynovectomy of the right ankle. Intraoperative and NIM monitor of the right lower extremity during the surgery.

01/28/13: The claimant was evaluated for maximal medical improvement and impairment rating. He complained of pain, numbness, and burning of the entire right foot all the time that was greater at night, greater in the heel, ankle, and during ambulation. He wore a Velcro brace. His treatment had included a work hardening program and physical therapy. On physical exam, SLR was negative bilaterally. He had 2/6 tenderness of the ankle and heel and posterior heel and some of the plantar surface of the foot, like a 3/4/10. There was no crepitation and swelling. Range of motion of the toes and foot and ankle appeared diminished. Dorsalis pedis and posterior malleolar pulses were good and equal bilateral. Right foot seemed slightly cooler and darker in appearance. Ankle valgus and varus tests were both positive with some stiffness and pain involved in both tests with active pressure. Patellar and Achilles tendon reflexes were 2+, equal bilaterally. Muscle strength was 3/5 on the right. SUMMARY AND COMMENTS: After completing of a comprehensive evaluation, the examinee was found to have not reached maximum medical improvement.

03/26/13: The claimant was evaluated for a behavioral medicine consultation. It was noted that before his right foot/ankle surgery, he underwent 20 days in a work hardening program. He completed 12 post-surgical PT sessions. It was also noted that his treating doctor and surgeon are "not able to continue prescribing narcotic pain medication." He noted that ibuprofen had caused bleeding so he was using less pain medication. However, he still depended on hydrocodone only on rare occasions as he would "no longer receive narcotic prescriptions." His medication list included alprazolam, Citalopram, hydrocodone/acetaminophen 10/300 mg, ibuprofen, Lisinopril. It was noted that his father had emphysema and committed suicide. The claimant reported no record of any mental disorders or

emotional issues impacting his independent functioning prior to the injury on xx/xx/xx. He rated his pain as 7/10. He described the pain as numbness, burning, and tingling in his foot and ankle. He reported difficulty with acts of daily living. It was noted that he could not stand for more than 1-2 minutes on his right foot and could not walk more than 10 minutes. He used a cane at all times. He lifted and carried at a maximum of 10 pounds. It was noted that he could use his right foot to press the gas pedal while driving but was unable to press the brake pad with his right foot. He reported insomnia. He rated his current level of functioning at 40%. BDI-II and BAI: 25 BDI-II, indicating moderate depression. BAI 37, reflecting severe anxiety. FABQ-W 42, FABQ-PA 24. It was recommended that he attend four sessions of individual psychotherapy.

03/27/13: The claimant was evaluated for followup from surgery on the right foot. He stated that the pain was a little better but mostly the same. He stated that he was to start seeing a pain management doctor in two weeks. On physical exam, he had minimal post surgery swelling. His mood and affect were normal. There was no sign of depression, anxiety, or agitation. His reflexes were active and symmetric. Sensation was intact. Dorsalis pedis pulses were intact. Posterior tibial pulses were intact. PLAN: He was to see pain management and start work hardening program. He requested pain medications and muscle relaxants. He was given a prescription for Norco 10 mg #40 and Soma 350 mg.

04/25/13: The claimant was evaluated by LCSW. BEHAVIORAL OBSERVATIONS: Affect constricted. Mood dysphoric. Physical presentation casually dressed. Attitude cooperative. Mental status oriented x 5. Participation level actively engaged. He rated his pain level at 7/10 and indicated that he was sleeping 5 hours.

05/07/13: The claimant was evaluated. FABQ: W-39, PA 22. BDI-II 45. BAI 43. After four individual psychotherapy sessions, his depressive symptoms continued to be in the severe range, even though he stated he was taking Citalopram and alprazolam. The severe symptoms of depression caused by current psychosocial stressors resulting from not being able to function as he did before his injury on xx/xx/xx. He stated that his mood was better on some days but it continued to fluctuate depending on circumstance. His mood was dysphoric. His affect was constricted. He verbalized cognitive distortions to include: magnification, catastrophic thinking or fortune telling, arbitrary inference, labeling, all or nothing thinking, disqualifying the positive and using "should" statements. PLAN: Chronic pain management program in order to reduce his pain and fear avoidance behaviors while improving his physical capabilities and functioning in order to propel him toward a safe return to work and facilitate medical case closure.

05/09/13: Functional Capacity Evaluation. RECOMMENDATIONS: Psychological evaluation. Participation in Chronic Pain Management Program. The remainder of the evaluation is illegible.

05/09/13: The claimant was evaluated. His current medications included BP meds, alprazolam, Citalopram, Norco 10, gabapentin, and Soma. CLINICAL

**FINDINGS:** Decreased ROM with dorsiflexion and plantar flexion. He had pain on palpation in the right foot. Strength was decreased at 3-4/5. Sensation intact. He was unable to toe walk. **RECOMMENDATIONS:** Chronic Pain Management Program.

05/28/13: The claimant was evaluated. **TESTING:** BDI-II 41, indicating severe depression. BAI 44, reflecting severe anxiety. FABQ-W 42, FABQ-PA 24. **TREATMENT RECOMMENDATION AND OBJECTIVES:** We concur with recommendation that the patient participate in the chronic pain management program after exhausting conservative treatment. Currently, he is negatively impacted by pain and reduced functioning across activities of daily living. He has responded positively to past treatment and failed to restore his functioning. He will require an interdisciplinary chronic pain program in order to reduce his pain and fear avoidance behaviors while improving his physical capabilities and functioning in order to propel this patient toward a safe return to work and facilitate medical case closure.

06/17/13: Request for 80 hours of a Chronic Pain Management Program. **SUMMARY:** Please recall that prior treatment modalities have failed to stabilize psychosocial distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. is approximately 1 year and 7 months status post injury. His pain is chronic, persistent, and intractable at 5-8/10, depending on his level of activity. Conservative care has not been sufficient to extinguish his pain or increase his functional tolerances such that he could successfully return to his previous position. He describes limited functioning with daily, job, and familial activities. He has developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. Mr. treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this patient's pain experience, develop self-regulation skills, and facilitate a timely return to the work force.

06/20/13: UR performed. **REVIEWER COMMENTS:** The evaluation/request for 80 hours of a chronic pain management program relates the injury, the immediate post-injury treatment, and notes that the patient had surgery for his right foot and ankle in 09/2012 after completing a "work hardening program." The patient completed about 12 sessions of physical therapy after the surgery and reported that "his treating doctor and surgeon are not able to continue prescribing narcotic pain medication." The patient stated that ibuprofen had caused bleeding, so he is using less pain medication. He continues to depend on hydrocodone, only on rare occasions, as he will no longer receive narcotic prescriptions. The patient participated in 4 individual psychotherapy sessions and psychological testing, and continues to report marked pain and unresolved functional problems that are associated with reliance on significant others to complete activities of daily living and unemployment. The request for the pain management program and the psychological testing appear to support that the patient would likely benefit from a pain management program. However, the ODG indicate the patient should not

repeat a same/similar program for the same injury. Without a conversation with the treating physician, it is not possible to certify the request as stated. The previous program was initiated while there were still options for treatment, including the surgery that was performed in 09/2012 after the previously attended program. I discussed the case who didn't have any additional information to support a repeat program.

07/03/13: UR performed. REVIEWER COMMENTS: The initial request was non-certified noting that the patient underwent right foot and ankle surgery in 09/2012 after completing a work hardening program. The patient completed about 12 sessions of physical therapy after the surgery and reported that his treating doctor and surgeon are not able to continue prescribing narcotic pain medication. The patient participated in 4 individual psychotherapy sessions. The ODG indicate the patient should not repeat a same/similar program for the same injury. Reconsideration dated 06/28/13 indicates that after 4 IPT sessions, the patient's depressive symptoms continue to be in the severe range even though he states he is taking Citalopram and alprazolam. Realistically, he might not reach a PDL of heavy. They will focus on him s reach a PDL of light to medium and search for jobs within that PDL. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has only completed 4 sessions of individual psychotherapy to date. The patient should exhaust lower levels of care prior to work hardening program.

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

The previous adverse decisions are upheld. The submitted FCE from 05/09/13 is illegible, and there is no summary outlining the current physical capabilities and no comparison to job of injury demands and, therefore, no quantifiable evidence of loss of function (ODG Criteria #1). Nor is there any validity criteria or comments regarding consistency of effort and, therefore, no documentation of motivation (ODG Criteria #7). There is also no documentation regarding vocational issues that require assessment (ODG Criteria #3). There is no indication of a treatment plan regarding expected outcomes/goals for return to function (ODG Criteria #6). There is also no treatment plan regarding management of psychotropic medications such as change of ineffective medication or weaning from or increasing current medication as part of the overall interdisciplinary program (ODG Criteria #6). Therefore, the request for Chronic Pain Management Program 5 x 2 x 80 hours Right Foot/Ankle 97799 does not meet ODG guidelines and is not found to be medically necessary.

ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p><b>Criteria for the general use of multidisciplinary pain management programs:</b>  <u>Outpatient</u> 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</p>
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	<p>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.</p> <p>(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.</p> <p>(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:</p> <p>(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;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected;</p> <p>(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;</p> <p>(d) An evaluation of social and vocational issues that require assessment.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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). (<a href="#">Sanders, 2005</a>) 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).</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> 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. (<a href="#">Keel, 1998</a>) (<a href="#">Kool, 2005</a>) (<a href="#">Buchner, 2006</a>) (<a href="#">Kool, 2007</a>) 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 <a href="#">Chronic pain programs, opioids</a>; <a href="#">Functional restoration programs</a>.</p>
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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)**