

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** August 5, 2013

**IRO CASE #:**

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

Chronic Pain Management Program 5 x 2 (10 Sessions/80 Hours)

**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 PM/Occupational Medicine with 34 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:**

06/25/13: FCE with Treatment Clinic  
07/03/13: Request for Services  
07/10/13: Preauthorization Request  
07/15/13: UR performed  
07/16/13: Reconsideration Request  
07/23/13: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his low back when he attempted to get up off the floor while working on xx/xx/xx.

06/25/13: The claimant was evaluated. RECOMMENDATIONS: does not meet critical physical demands of his previous position of employment, which is classified as Medium to Heavy job demand level under the Dictionary of Occupational Titles. He demonstrated the ability to function as a sedentary light level. At this time, it is recommended that progress into a Chronic Pain Management Program. There is an apparent level of depression and anxiety

present at this time. It makes it difficult for lasting improvement to take place due to a lack of effective coping strategies demonstrated by the patient. Mr. states that he is currently depressed due to loss of functioning, a loss of independence, and response to dealing with his injury. I feel that a Chronic Pain Management Program will be beneficial for my patient. Rendering treatment will facilitate progression towards case resolution.

07/03/13: Request for 10 Sessions of Chronic Pain Management Program. It was noted that the claimant had completed psychotherapy sessions and was making minimal progress due to poor coping skills, anxiety, depression, and pain complaints. BDI-II 16; after completion of individual therapy sessions 12. BAI 12, after individual therapy sessions 10. SUMMARY: The pain resulting from his injury has severely impacted normal functioning physically and interpersonally. Patient reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain has reported high stress resulting in all major life areas. The patient will benefit from a course of pain management. It will improve his ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting his daily functioning. Patient should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists of, but is not limited to, daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of functioning as possible.

07/15/13: UR performed. CONCLUSION: I spoke on 07/12/13 at 1:39PM CT. He stated that surgery has been recommended but it was denied. He stated that the insurance carrier is currently disputing the disc herniations as compensable. He stated that the claimant does not have a job to return to so that is why a chronic pain management program was selected over work hardening. Recommend adverse determination. ODG guidelines state that "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." Surgery has apparently been recommended. If the claimant has a surgical condition, whether work related or not, this should be addressed prior to consideration of a chronic pain program. Moreover, the claimant's psychometric testing, BDI and BAI, is mild or normal so it is not clear that such an intensive program is necessary. The request is not consistent with ODG recommendations.

07/16/13: reviewed the denial given. noted that the claimant had exhausted all lower levels of care and was pending no additional procedures. He stated that met the criteria for general use of multidisciplinary pain management program according to ODG pain chapter.

07/23/13 UR performed. CONCLUSION: I spoke on 07/23/13 and the case was discussed. Additional medical information was not provided. I voiced to him my concerns. Recommend upholding the initial adverse determination. A request for spinal surgery was submitted to utilization review on 07/19/13. So, as of just a few days ago, the patient was seeking spinal surgery. This is problematic given the ODG criteria for CPMP #2. Some surgeon clearly thinks that the patient has other (surgical) treatment options that are likely to lead to significant clinical improvement. There should not be concurrent requests for surgery and a CPMP since those are mutually exclusive concurrently. There is also documentation that there is an ongoing patient-carrier dispute regarding the extent of the injury of whether or not the disc herniations are compensable. This determination is important because this is resolved, there is clear evidence of the claimant wanting to perpetuate his claimant status. CPMP criteria #7 is not met. This patient either does or does not have a surgical lesion. If he has a compensable lesion, then he may well need surgery under the WC system. If he has a non-compensable lesion, then he needs surgery outside of the WC system. In either case, a CPMP is not supported. See criteria #3a and the initial level adverse determination reason. If the extent of injury determination does not involve disc herniations and the extent of injury is a strain, then there would be no medical need for a patient who only sustained a compensable strain with normal BDI and BAI psychometrics to undergo a CPMP.

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

The previous adverse decisions are upheld. This worker sustained an on-the-job injury to the lumbar spine. Records indicate that surgery was requested as well as subsequent request for Chronic Pain Management Program. Simultaneous requests for chronic pain management and surgery treatment have been resubmitted on behalf of the claimant. ODG criteria do not support treatment with Chronic Pain Management if a surgical lesion is present unless surgery is optional, controversial, or avoidable. The submitted documentation is insufficient to determine whether the disc herniations require surgery. The request for Chronic Pain Management Program 5 x 2 (10 Sessions/80 Hours) does not meet ODG criteria and is not 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 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</p>
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	<p>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 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</p>
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	<p>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)**