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Notice of Independent Review Decision

Date notice sent to all parties: 9/26/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 5x/2 weeks-80 units

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

Texas Licensed, Board Certified Psychiatrist

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Notice of IRO Assignment
2. LHL009
3. 8/12/13 and 8/22/13 Denial letters
4. 8/5/13 Request for Services
5. Treatment Plan
6. 6/29/13 Functional Capacity Evaluation Report
7. 8/15/13 Request for Reconsideration
8. 9/12/13 letter to Allmed Review Services
9. 8/7/13 Pre-authorization Intake Form

PATIENT CLINICAL HISTORY [SUMMARY]:

sustained a knee injury on the job on xx/xx/xx and he had the various treatments as described in the letter. This included psychotherapy, work hardening, and opiates. The details of these as well as the exact medical problems with the knee were not described. He has requested that he be placed a multidisciplinary chronic pain management program. It was noted that the program is designed to aid the claimant in dealing with depression, anxiety, and pain syndromes. The claimant had previously completed psychotherapy sessions, as noted above, was noted to have made minimal progress. The claimant was noted to have had a negative thought processes as well as feelings of inadequacy, fear, failure, secondary to his ability to function in activities of daily living. There were also symptoms of depression and anxiety secondary to chronic pain syndrome as well as high level of stress, poor sleep duration, low self worth, high levels of frustration, and physical limitations resulting from the injury, including a fear of re-injury. A functional capacity evaluation dated on 05/29/2013 stated the claimant had complained of severe stabbing and throbbing pain of the entire left lower extremity and left hip. The pain was stated to be still unbearable that the claimant was bedridden up to a week at a time. During this evaluation, there was normal sensation to bilateral upper and lower extremities. There was normal range of motion for the left and right knee. Range of motion for the right knee was stated to be from 0 to 142 degrees. Evaluation found the claimant to be functioning in the sedentary physical demand level.

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

It is noted that made the initial refusal to authorize the multidisciplinary chronic pain management program. In his report, he stated that he discussed the case. This man reported that claimant finished ten sessions of work hardening and his continuing problems were psychological. The claimant showed an increase in anxiety and an increase in depression. The claimant is at a sedentary physical demand level, but requires a heavy PDL to return to work. noted that the claimant is currently only taking over-the-counter medicines for pain. The minimal notes available in the enclosed medical records from the therapist showed no evidence

that the claimant indeed suffered from chronic pain syndrome and accordingly, there is no evidence that there is a substance dependence on health care providers, spouse, or family. also noted there was no evidence that there is any withdrawal from social activities and normal contact with others. He also stated there was no enclosed physical examination that ruled out any condition that required treatment prior to initiating this program. There is also not a stated diagnosis included. Guidelines also states there should be some documentation that the claimant had motivation to change and is willing to change the medication regimen; however, the note from the therapist specifically stating that the claimant had difficult times being motivated to perform necessary actions for successful recovery, making success other than a chronic pain management program unlikely. Also due to the claimant's reported high level of pain there is concern with possible substance abuse issues, an evaluation for addiction condition completed prior to recommendation of this program could be beneficial. As such the request for chronic pain management at five times a week for two weeks, including 80 units would not be considered medically necessary or appropriate. Therefore, he recommended non-certification.

This was appealed and, also recommended non-certification. In his opinion, according to the clinical documentation, the patient who is a individual, who sustained an injury on xx/xx/xx. The patient tripped over a piece of wood behind the patient and fell, twisting the left knee. The patient's knee gave way and seemed to be out of place. The patient straightened the leg out and pushed on the knee and it popped back into place with severe pain. The patient had swelling of the knee afterwards. According to request for consideration dated 08/15/2013, the patient exhausted all lower levels of care and was pending no additional procedures. The guidelines considered tertiary chronic multidisciplinary pain program to be the standard treatment. The chronic interdisciplinary pain program was the recommended course of treatment to help patient return to work. The patient met this criteria for general use of multidisciplinary pain management program. According to request for service notes dated 08/05/2012 patient had completed group therapy sessions (no total number of visits documented) when in the work hardening programs and approved individual therapy sessions. The physician recommended a multidisciplinary chronic pain management program to aid patient in dealing with depression, anxiety, and pain symptoms associated with both psychological factors and general medical condition, and chronic pain. The patient completed psychotherapy sessions (no total number of visits documented); unfortunately, patient made minimal progress, due to large part poor coping skills, anxiety, depression, and pain complaints. The patient demonstrated minimal progress. The program requested would enable the patient to make successful transition to a high level of functioning and return to work. The patient complained of anxiety, depression, muscular tension, and developed chronic pain symptoms, had not been able to return to work. The patient reported high levels of stress daily. Source of stress was reportedly to be the patient's multiple problems since the injury. Some of the stressors included lack of financial stability and lack of overall physical functioning. The patient stated that since there was so much pain and patient not been able to work regularly, patient has had a difficult time

structuring life, remaining positive, and being motivated to perform the necessary actions for successful surgery. Because of this, patient was under a great deal of pressure from his own self to recover as successfully as possible and return to work as patient would fulfill the necessary work responsibilities. The stress caused the patient's pain to increase and while the patient was in session, patient stated that feelings the patient was beginning to learn to decrease the pain. However, patient had difficulty maintaining levels of pain low enough for a period of time, so that patient could productively function. Because of the patient's high level of daily stress, the patient has been unable to effectively cope with the pain. During sessions of counseling, patient demonstrated negative thought processes which cognitive training would help, symptoms of depression and anxiety secondary to chronic pain syndrome, feelings of inadequacy, fear, and failure secondary to inability to function in activities of daily living, high level of stress due to injury and losses, poor sleep duration, low self worth, high levels of frustration, physical stress due to injury and losses, poor sleep duration, physical limitations and other resulting losses from the injury and fear of re-injury and increased level of pain. The patient continues to suffer from anxiety and depression. The patient required intensity outpatient chronic pain program to assist in overcoming the fears, feelings, thought processes in daily life since the injury. Limited psychotherapy proved to be mildly useful and helpful as evidenced by patient's rapport with the therapist and patient's willingness to share feelings and talk openly about problems. Unfortunately, this limited amount of therapy was insufficient to meet the patient's needs (eg, help the patient improve the ability to more effectively manage chronic pain and reduce pain level). As therapy continued it became apparent that the patient's coping skills were improving; they were still weak due to the patient becoming being easily discouraged and too emotionally unstable to be consistent to follow up with the treatment plan. The patient had difficulty reducing pain level and resisted limiting the efficacy of talk and thought pattern. Note in the final session the patient continued to verbalize disappointment with the situation, depressed feelings, stress, tension, and inadequate coping skills. Despite interventions to lower stress levels and teach coping skills, the patient still reported very high levels of stress that he was unable to lower through individual therapy. The patient showed progress in decreasing levels of pain. Before participating in psychotherapy sessions, the patient reported that the average levels of pain fluctuating between 6-10/10. The patient reported that levels of pain on average to be around 6/10. The patient reported that physically and emotionally, there was improvement while performing physical therapy exercise and attending approved group therapy sessions; however, the overwhelming fear of re-injury, along with the lack of solid coping skills was holding the patient back from successfully achieving the level of perform which the patient needs to return to work and complete his necessary job requirements. The patient had exhibited interest in commitment throughout the various treatments. The patient reported suffering from severe fear future re-injuring and other return to work concerns; however, after completion of a few psychotherapy sessions, patient began to understand the fears are not only irrational in nature, but also holding him back from successful recovery. The patient reported that the patient had "always worked my whole life and wanted to go back, but I just worry that I

couldn't do my job the way I used to." The patient reported not only desire to return to work when the patient has emotionally and physically recovered from injury, but had also discussed with the therapist that the patient wants to participate in future program such as Department of Assistive and Rehabilitative Services (DARS), to promote return to work success. The patient's Beck Depression Inventory-2 score following completion of repeat interview was 28, which was in the moderate range of the test. After completion of individual therapy sessions, the patient was once again administered the same assessment and scored a 24, within the moderate range of the test. The patient's Beck Anxiety Inventory was 28, which was within the moderate range of the test. After completion of individual therapy session, the patient was once again administered the same assessment scored a 24. The patient's screener and opioid assessment for patients in pain score was 18 which indicated a high risk for abuse of prescribed narcotic pain medications. At the completion of individual therapy sessions, the patient was once again administered the same assessment and scored a 19. The ten sessions of behavioral multidisciplinary chronic pain management program request enhanced coping mechanisms to more effectively manage pain and achieve success in rehabilitation. It would be crucial that the patient would receive other necessary components, which were not provided in individual therapy, to complete the tools needed to see an increase in overall level of functioning. This program was composed of a multidisciplinary team of professionals which were specifically trained to address the patient's needs (e.g., fears of irrational beliefs and thoughts), which were not met through psychotherapy. In the multidisciplinary chronic pain management program, the patient will receive the tools necessary to remove or address both psychological and physical barriers. With the requested program, the patient would be encouraged to start with small goals that may feel helpful. After experiencing some success, the patient would be able to motivate to advance to bigger goals. Any slight improvement experienced by the patient would help increase the patient's hopes to recovery. The patient's therapist opined that the patient should be treated 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 consist of, but not limited to, daily pain and stress management, group relaxation exercises, interventional therapy, nutrition education, medication management, and vocational counseling as well as physical activity groups. These intensive services would address the current problems in coping, adjusting, and returning to high level of functioning as possible. Functional capacity evaluation report dated 05/29/2013 (unsigned) documented patient was classified as sedentary physical demand level. The patient's job required the patient to be able to function at a heavy physical demand level. Considering the high pain levels and results of the psychological evaluation, a structured chronic pain program with cooperation and multidisciplinary narcotic reduction program is recommended as the best option to bring resolution to this matter. The goal for the patient's program would be to improve physical demand level and capabilities for further vocational opportunities upon release to DARS vocational retraining. The patient was diagnosed as spasm of muscle; edema, other joint derangement, not elsewhere classified, lower

leg, and unspecified internal derangement of the knee. The previous denial letter was not submitted at that time.

There was no rebuttal of the previous denial noted but did note that the evaluation plea was completed administered screening inventories. The screening inventories were not, in his opinion, sufficient to document the psychological necessity of the CPMP program. There is also not a report provided by the program medical director or the program pain psychologist. As such the chronic pain management 5x/2 weeks - units is not medically necessary and appropriate. He recommended non-certification.

In my opinion, I agree Not only was there relatively little in the way of a multidisciplinary evaluation, there were no notations about the original knee injury, the results of any imaging, or other data in this request. Also, I agree that the screening tools were insufficient for the demands of the ODG guidelines.

The request for chronic pain management 5x/2 weeks-80 units is not medically necessary. In (3) of the ODG Treatment, Pain (Chronic), updated June 7, 2013, criteria for the general use of multidisciplinary pain management programs; Outpatient pain rehabilitation programs may be considered medically necessary when an adequate and thorough multidisciplinary evaluation is made. The ODG details the various steps that must be followed.

These steps were not done adequately enough to meet these guidelines. Only some psychological screening tests were used and these, in my opinion, were not sufficient. Also, the evidence that he was suffering from a psychogenic pain syndrome was unclear. Mr. has relatively recently claimed that he has had to cut his pants off four times due to swelling of his leg, and this seems to indicate possible physical pathology that was not accounted for in the physical examination or the reports.

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
- X 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
- X 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):