



## Notice of Independent Review Decision

**February 18, 2013**

**IRO CASE #:**

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

Chronic Pain Program 5 x week x 2 weeks CPT 97799

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

American Board of Physical Medicine and Rehabilitation

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)

## **IRO REVIEWER REPORT - WC**

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:**

#### **MEDICAL RECORDS REVIEW**

- 7-11-12 MD., office visit.
- 10-1-12 MD., office visit.
- 10-9-12 DC., office visit.
- 10-17-12 MA., office visit.
- 10-22-12 Functional Capacity Evaluation.
- 12-17-12 Functional Capacity Evaluation.
- 1-4-13 MA., office visit.
- 1-31-13 WorkLink: Letter.
- 1-23-13 DC., request for reconsideration.

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

MD., the claimant was driving with bad battery. Liquid on engine caused fumes. These gave her symptoms. She was seen at the ER. She has improved a little but continues to have headache and nausea. Assessment: Chemical Inhalation, nausea, headache. Plan: The claimant was prescribed Esgic and Zofran.

10-1-12, MD., the claimant is employed as a xx. The claimant states that on xx/xx/xx, she was driving her bus, she started smelling a substance like rotten eggs which was later determined to be battery flumes. The claimant dropped off her xx and returned. She begin having headaches and coughing. She went to the Emergency Room that night, they did x-rays, blood work and diagnosed her as having carbon monoxide poisoning. The evaluator thinks in reality this claimant was probably exposed to hydrogen sulfide gas or sulfuric acid from the battery. The claimant has had continued difficulty with headaches and nausea. She was treated

## IRO REVIEWER REPORT - WC

with Butalbital, Meclizine, and Zofran. She states that she has been having difficulty with headaches and nausea. The headaches are random in location and accompanied by sharp pain. Two weeks ago she had an explosion like feeling in her head. She has not had a CT or an MRI. The headaches are occurring on a daily basis. Assessment/Plan: More than likely this patient's headaches are rebound headaches from the treatment that she is receiving. The evaluator would strongly recommend that the Butalbital, Meclizine, and Zofran be stopped. If anything, the evaluator would treat the headaches with an anti-inflammatory medication. The evaluator does not think at this point that CT or MRI would be related to this claimant's occupational claim. She might want to obtain these studies through her regain insurance. In any event, the evaluator will provide this report to her treating doctor who can then implement this plan.

10-9-12, DC., the claimant presents with headaches. Impression: Carbon monoxide, dizziness, nausea, vertigo. Plan: The evaluator recommended the claimant to undergo 8 sessions of active care to treat overall deconditioning.

10-17-12, MA., the claimant presents for Psychological Evaluation. Diagnosis: Axis I: Pain disorder with both psychological factors and a general medical condition, acute. Axis II: Deferred. Axis III: V87.2, 339.10. Axis IV: Chronic Pain, financial straggles, multiple social losses, and problems with family. Axis V: GAF=60. Plan: It is recommended that the claimant be seen for six (6) sessions of individual psychotherapy.

10-22-12 Functional Capacity Evaluation shows the claimant is functioning at a Medium PDL.

12-17-12 Functional Capacity Evaluation shows the claimant is functioning at a Medium PDL.

1-4-13, MA., the claimant presents for Psychological Evaluation. The pain resulting from her injury has severely impacted normal functioning physically and interpersonally. The claimant 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 claimant will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. The claimant 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.

## IRO REVIEWER REPORT - WC

1-8-13 WorkLink: UR notes that requested treatment was denied per MRO, Dr., MD: the request for this comprehensive program is not reasonable or necessary, as there is no evidence of physical injury to be treated in physical therapy component. It does not meet ODG.

1-31-13 WorkLink: On 1-23-13 WorkLink was asked to perform a clinical review of medical treatment on the claimant which was proposed and/or provided by Health Trust. Diagnosis: Tension type headache, contact with and (suspected) exposure to other potentially hazardous chemicals. Employee did not attend approved individual psychotherapy sessions. Symptoms of anxiety and depression were noted to be mild to WNL from evaluation dated 1-4-13. Symptoms had not worsened since an earlier evaluation dated 10-11-12. Further evaluation dated 1-4-13 noted no prescription pain medication, pain levels had decreased from an 8 on 10-17-12, to 5 in 1-4-13. Evaluation 1-4-13 noted use of OTC medications only to manage pain. Apparent recent use of Hydrocodone 7.5 mg TID from Peer to Peer with Dr. on 1-30-13. Request does not meet ODG.

1-23-13 DC., the evaluator noted that after reviewing the file and the rationale given in Dr. denial, it was determined that they should proceed with the reconsideration process. This request should include a brief explanation of why they felt they had an unfair review. The claimant has exhausted all lower levels of care and is pending no additional procedures. Official Disability Guidelines from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment. The results of an outcome study performed by demonstrated that claimants who do not complete chronic pain program are 7 times more likely to have post-rehabilitation surgery in the same area and newly 7 times more likely to have more than 30 visits to a new health provide in persistent healthcare-seeking efforts. The study also demonstrated that claimants who do not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and 7 times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program in the recommended course of treatment to help on injured worker return to work and is considered the treatment of choice by the national standards cited above. The claimant meets the criteria for the general use of multidisciplinary pain management program, according to Official Disability Guidelines, chronic pain chapter: Outpatient pain rehabilitation programs may be considered medically necessary. Services to be rendered in this case are designed to accomplish the foregoing. Medical necessity for services to be rendered is clearly documented in this case. The evaluator would like the opportunity to have a peer to peer discussion with your reviewing doctor if they have any questions regarding the information received on this claimant.

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

## **IRO REVIEWER REPORT - WC**

Based upon the medical documentation presently available for review, Official Disability Guidelines would not support this specific request to be one of medical necessity, as it would not appear that lesser levels of care have been exhausted. Additionally, there is no indication that an objective diagnostic assessment is present to support the presence of a structural abnormality referable to the physical structure of the body which would support a medical necessity for such an extensive program. As a result, the above noted reference would not support a medical necessity for such an extensive program at the present time for the described medical situation in this case. Therefore, the request for Chronic Pain Program 5 x week x 2 weeks CPT 97799 is not reasonable or medically indicated.

### **Per ODG 2013 Chronic Pain Management Program: 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

## IRO REVIEWER REPORT - WC

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

## IRO REVIEWER REPORT - WC

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, outpatient 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.

## IRO REVIEWER REPORT - WC

Inpatient 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. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) 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 Chronic pain programs, opioids; Functional restoration programs.

## IRO REVIEWER REPORT - WC

### 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)