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Notice of Independent Review Decision

**Date: January 28, 2013**

**IRO CASE #:**

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

10 sessions of chronic pain program

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

Psychologist  
International Neuropsychological Society  
American Psychological Association

**REVIEW OUTCOME:**

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

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

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- FCE (07/27/12)
- Office visits (11/15/12 – 11/20/12)
- Utilization review (12/07/12)

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- FCE (07/27/12)
- Office visits (08/02/12 – 11/20/12)
- Utilization reviews (08/20/12, 09/13/12, 12/07/12)

**TDI:**

- Utilization reviews (12/07/12, 01/14/13)

ODG has been utilized for the denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was working as a xx. On xx/xx/xx, he was working in the basement of a xx when a water pipe which was located on the ceiling burst open. The water and its pressure pushed the patient back. As he turned to run away, he injured his neck and back and also reported pain in his shoulders and knees.

No records are available for years 2010 and 2011.

On July 27, 2012, the patient underwent a functional capacity evaluation (FCE). The evaluator reviewed magnetic resonance imaging (MRI) of the lumbar spine dated October 20, 2010, that revealed moderate desiccation and severe narrowing of the interspace with a few millimeters of retrolisthesis at L5-S1 and a prominent central disc extrusion 9 mm sagittally, 1.7 cm transversely and 9 mm cephalocaudad contacting the anterior thecal margin and bilateral S1 roots. The MRI of the cervical spine dated October 28, 2010, revealed posterolateral 4-mm disc herniation on the right at C5-C6 creating compression of the right side of the cord with C5 nerve root and foraminal compromise, broad-based annular bulge at C6-C7 and straightening of the normal cervical lordosis. The patient qualified at a light physical demand level (PDL) versus heavy PDL required by his job. The evaluator felt that the patient was a good candidate for a functional restoration and/or transition of care program to address the deficiencies identified and expedite full return to work.

On August 2, 2012, Ph.D., evaluated the patient for pain primarily in the legs, knees, neck and shoulders. The pain was described as constant, throbbing, wrenching, stabbing, annoying, irritating, pins and needles, worrisome, piercing, burning, tingling, numbness, aching, sharp, shooting and aggravating. He also experienced symptoms and feelings of sadness, anger outbursts, helplessness, inability to sleep, isolation, difficulty concentrating, discouraged about the future, increased irritability, inability to relax, loss of interest, fatigue, easily emotional, hopelessness, increased pain with tension, appetite decrease, nervousness, decreased motivation, increased sensitivity, lack of sex drive, loss of pleasure and short temper. The patient felt that he was functioning at approximately 10% of his pre-injury capacity. His treatment history included physical therapy (PT), transcutaneous electrical nerve stimulation (TENS) unit, two injections in the neck and back surgery, all of which only provided short-term, marginal results. He reported pain in the neck, back, legs and shoulders. He also reported numbness in the legs. His increased pain levels had reduced his overall activity which had resulted in general deconditioning. He had difficulty with walking, sitting, standing, lying down, lifting, reaching and squatting. The patient reported pain-related elevated blood pressure. He scored 43 on Beck Depression Inventory (BDI)

indicating severe depression, 45 on Beck Anxiety Inventory (BAI) indicating severe anxiety, 74/100 on Oswestry Index indicating that the patient was in the crippled disability range, 23/24 on Fear Avoidance Beliefs Questionnaire (FABQ) indicating a severe level of fear and avoidance beliefs about physical activity, 42/42 indicating a severe level of fear and avoidance about work activities, 68 on Brief Pain Inventory (BPI) indicating pain impinges with activities of daily living (ADLs) on a severe level and 8 on SOAPP-R indicating risk of aberrant medication-based behavior. The patient was sleeping 4 hours per 24-hour period. His pain level was best at 4/10, worst at 9/10 and average was 5/10. His previous medications included hydrocodone and cyclobenzaprine. Dr. diagnosed pain disorder associated with both psychological factors and a general medical condition, headaches, sprain/strain of neck, lumbar intervertebral disc (IVD) without myelopathy, spasm of muscle, tinnitus, and noise-induced hearing loss and lumbar status post surgery. He recommended a trial of 10 sessions of treatment in an interdisciplinary pain management program.

Per utilization review dated August 20, 2012, Ph.D., noted the following treatment history: *"The patient had a history low back, bilateral lower extremity, bilateral knee, neck and bilateral shoulder pain complaints, following reported fall injury when a pipe blew up. There was reported consequent bilateral hearing loss and tinnitus. Dr. asserted that the latter had not been addressed. Treatment has included conservative care, ESIs, brief psychotherapy and lumbar laminectomy and discectomy. There was a premorbid history of low back injury, details unknown. Current medications included hydrocodone and cyclobenzaprine; dosages not reported.*

Dr. denied the request for 10 sessions of chronic pain management program (CPMP) with the following rationale: *"Dr. discussed this case and the requested procedure with Dr. on August 20, 2012 11:00 AM CT. I do not recommend certification of 10 sessions of an interdisciplinary chronic pain rehabilitation program for the following reasons: The psychological evaluation of August 2, 2012, finds impression of pain disorder. However, this is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms, and to help design and predict response to treatment; and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e.. pain complaint, behavior, and disability), to enable a "better understanding of the patient in their [sic] social environment," or to provide "a cogent explanation for the identified complaints and dysfunction." The cause of the continued or exacerbated complaints and dysfunction was queried further. The only offered explanation was "fear avoidance." This is not supportable as a reasonable explanation. Despite popular use of this concept, it has not been shown to be a significant factor in delayed recovery or the evolution of chronicity of low back pain; and it has not been systematically studied in other chronic pain presentations. There is no current history and physical by the physician who Dr. reports would be attending the patient in the program (Dr.).*

*This is inconsistent with appropriate practice, as not having seen the patient, he is not in a position to participate in the multidisciplinary decision for this treatment; and since this would not occur for "a few days" post-admission, this significantly delays formulation and implementation of a full, comprehensive treatment plan. There is no documentation or known finding that the patient's treating physician (Dr.) has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. Part of this care may involve clinical attention to the problem of the patient reportedly not wearing his hearing aids. It is now reported that he "doesn't like to wear his hearing aids ... feels people are judging him." It is now admitted that the provided psychotherapy did not sufficiently address this; and I actually can find no documentation that it was addressed at all. Compliance with wearing hearing aids is a well-known problem. However, in a patient with a chronic benign pain syndrome this is often related to the pain complaints and behavior as well. The perception of social consequences (real or not) often enables negative reinforcement of pain and illness behavior, thus promoting continued or enhanced dysfunction. Such problems are generally responsive to appropriate behavior therapy methods (in psychotherapy). However, this has not been seriously attempted, for unknown reasons; and I can find no documentation on this, and there is actually no behavioral assessment at all in the psychological evaluation. That such issues would be addressed psychologically in the program, as now offered, is not reasonable. It is not indicated to provide a full-time chronic pain program for a clinical problem which could likely be effectively addressed in individual psychotherapy. If such is effective (and this is generally not a difficult problem to address), resulting in modification of pain and illness behavior, then it is not clear that such, in combination with home exercise, cannot be effective in significantly reducing dysfunction and return to some type of employment. The clinical outcome, of course, cannot be projected; but the treatment has not been attempted. The argument that he should increase his "physical demand level" is irrelevant. First, there is no specific job to return to; and it is not the job of a pain program to return the patient to a given PDL. Second, this cannot be assessed with an FCE, as done here. There is no quality evidence that such tests have reasonable reliability and validity in patients with chronic benign pain, and they are not actually measures of work "capacity. A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, without appropriate assessments and attention to the above matters. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended. The request is inconsistent with the specifications that "Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met, [including] ...an adequate and thorough multidisciplinary evaluation has been made ... there is an absence of other options likely to result in significant clinical improvement."*

On August 30, 2012, Dr. requested for psychological diagnostic interview and two hours of psychological testing.

On November 15, 2012, the patient underwent psychological diagnostic interview. He scored 43 on BDI indicating severe depression, 45 on BAI indicating severe anxiety, 74/100 on Oswestry Index indicating that the patient was in the crippled disability range, 23/24 on FABQ indicating a severe level of fear and avoidance beliefs about physical activity, 42/42 indicating a severe level of fear and avoidance about work activities, 66 on BPI indicating a decrease in pain symptoms and 8 on SOAPP-R indicating risk of aberrant medication-based behavior. The patient was sleeping 4 hours per 24 hour period. His pain level was best at 4/10, worst at 9/10 and average was 5/10. His medications included hydrocodone and cyclobenzaprine. Dr. diagnosed pain disorder associated with both psychological factors and a general medical condition. The evaluator recommended a trial of 10 sessions of treatment in an interdisciplinary pain management program.

On November 20, 2012, M.D., evaluated the patient for throbbing pain in the low back. Examination revealed painful cervical movements and paravertebral tenderness. Neurological examination revealed radiating pain in the upper extremities with headaches, right and left scalp and shoulder region. Dr. assessed neck pain, headaches and pain radiating to the shoulders. He recommended follow-up with Dr., an orthopedic surgeon, obtaining a cervical MRI and follow-up in four weeks.

Per utilization review dated December 7, 2012, the request for 10 sessions of CPMP was denied with the following rationale: *"The clinical indication and necessity of this procedure could not be established. The below psychological evaluation is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms, and to help design and predict response to treatment; and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e., pain complaint, behavior, and disability), to enable a "better understanding of the patient in their [sic] social environment," or to provide "a cogent explanation for the identified complaints and dysfunction." The current evaluation of this patient is not a "complete diagnostic assessment." There is no current history and physical by the medical director or a physician associated with the pain program. This is not satisfied by the submitted FCE of July 27 (now 4.5 months old), which contains no thorough examination, review of systems, or diagnosis. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. When I reviewed this same request recently with Dr. from this program; deficiencies in the request were noted, including a history & physical by program personnel and the issue of the patient's hearing loss, compliance with wearing his hearing aids, and whether previous psychotherapy had addressed that problem (on which was not able to comment at the time). Subsequently, 4 psychotherapy visits were certified*

October 11, 2012; but no notes are submitted, and it is unclear if that problem has been addressed. There is also no H&P such that the program physician may contribute to the admission decision and treatment planning, inconsistent with appropriate care for a chronic pain program. A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, without these assessments. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended.

Per reconsideration review dated January 14, 2013, the appeal for 10 sessions of CPMP was denied with the following rationale: *“Clinical data submitted indicates the worker has been repeatedly referred for enrollment in a chronic pain management program but has been met with opposition in the form of the pre-certification reviews by Dr. who has opined the psychological evaluation is inadequate to support enrollment in such a program. Noting the worker has participated in three formal psychological evaluations by Dr. (March 25, 2011, August 2, 2012 and November 15, 2012) all of which used similar and commonly employed screening tools (BAI, BDI, FABQ, Oswestry, BPI and SOAPP, in addition to clinical interview and the outcome of six sessions of individual counseling). The prior reviewer appears to suggest that psychiatric diagnostic testing is required in order to be considered for participation in a multidisciplinary rehabilitation program of this nature. Such studies would include, according to the clinical guidelines (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory. The ODG cites 26 various psychological tools that may be used in the assessment of not only pain disorders but also the evaluation of mental health disorders in addition to anxiety and depression. The guidelines cite medical literature that states maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the Injury and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at work. These same guidelines provide a stepped approach to the evaluation and treatment of chronic pain syndrome.*

*The worker is noted to have been exposed to an explosion with the nature and extent of actual physical injuries seeming to be under some degree of contention based on various reports that have been submitted/reviewed (reference RME comments). The worker is noted to have undergone recent bilateral L5-S1 decompression laminectomy (January 31, 2012) and now complains of persistent low back and radicular pain associated with the L5-S1 intervertebral disc space and the presence on pre-operative MRI and EMG of positive findings consistent*

*with a neurocompressive lesion and electrophysiological abnormalities. Also, the worker is reported to have hypertension as a comorbid condition but it is not clear that cardiovascular monitoring was incorporated into the physical abilities assessment despite the treating physician recording that resting blood pressure is elevated to 150/95 in the office setting (November 20, 2012). The worker is noted to have undergone lumbar spine surgery that failed to promote functional recovery and the worker is noted to have comorbid conditions and a level of voluntary functional activity tolerance that is likely to be inconsistent with return to prior or similar work activities. The worker is noted to have developed psychosocial barriers to recovery for which he has received limited individual counseling and treatment to date. The worker continues to report elevated perceived pain levels and expresses concern regarding the potential for further injury or aggravation of his condition. The initial pre-certification reviewer opined that more detailed psychometric testing and identification of a physically compatible vocational goal was necessary prior to consideration for enrollment in the chronic pain management program. None of these conditions have been altered since that opinion was expressed; hence the medical necessity cannot be established at this time.”*

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

The claimant was injured 2 ½ years ago. He has been treated with both primary and secondary treatments. His pain continues and he remains dysfunctional. His treating physician states that all treatment methods have been exhausted. He has had numerous psychological evaluations as well as psychotherapy with the same psychologist who reports that he is very familiar with the claimant and believes him to be suitable for the program. The request for 10 sessions of a chronic pain management program has been denied due to a difference in opinion regarding the suitability of the tests that have been used to evaluate the claimant being psychological appropriate for the program. As noted, the treating psychologist is familiar with the claimant and should be able to determine his appropriateness for the program. He does meet the ODG criteria for participation in a chronic pain management program and thus the request for 10 sessions of the program can be certified as medically necessary.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Pain Chapter. 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 healthcare 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 pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (3) 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 loss 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 program 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