

# The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

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## Notice of Independent Review Decision

**February 7, 2014**

**IRO CASE #:**

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

Medical Necessity: Chronic Pain Management Program 5X Week for 2 weeks

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

I certify that I hold appropriate credentials to conduct this review. I received my medical degree from the University of Health Sciences College of Osteopathic Medicine in Kansas City, MO. I completed a physical medicine and rehabilitation residency at Northwestern University Medical School. I hold active and unrestricted licenses in Texas and Ohio. I have experience producing Peer Reviews supported by evidence-based medicine and have experience with worker's compensation claims. I am Board Certified in Physical Medicine and Rehabilitation by the American Board of Physical Medicine and Rehabilitation and Board Certified in the subspecialty of Pain Medicine by the 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)
- 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.

*Upon independent Review the physician finds that the previous adverse determination should be Upheld*

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

Records Received: 28 page fax 1/21/14 Department of Insurance IRO request, 108 pages of documents received via fax on 1/22/14 URA response to disputed

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services including administrative and medical. Dates of documents range from xx/xx/xx to 1/21/14.

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

The patient is a male who reported an injury to his right knee on xx/xx/xx, when he was reported to be running and he reported as he ran, he felt a pop in his right knee and felt immediate intense pain in the right knee. The patient is noted to have treated conservatively with physical therapy, chiropractic care, a TENS unit, and is noted to have undergone an MRI.

On 08/22/2013, the patient is noted to have undergone a right knee arthroscopy with partial meniscectomy and is reported to have treated conservatively with postoperative physical therapy for an unknown number of sessions. He is noted to have undergone an initial interview on 08/16/2013, which reported an impression that there was a strong indication the patient was experiencing pain that created interference with his life, and it appeared he was having long-term adjustment problems of depression and anxiety secondary to his injury. The patient is noted to have undergone a Beck Depression Inventory, and was reported to have scored a 28; and a Beck Anxiety Inventory with a score of 22. He was recommended for 6 sessions of individual psychotherapy. The patient is reported to have completed the 6 sessions of postoperative physical therapy and a work hardening program for an unknown number of sessions.

On 11/18/2013, a Functional Capacity Evaluation noted the patient did not meet the critical physical demands of his previous position of employment, which required a heavy capacity. He was reported to have demonstrated under a light capacity. The patient was noted to continue to have decreased range of motion and flexibility of the right knee with associated pain. On 11/18/2013, a request for 10 sessions of chronic pain management program was submitted. The patient was noted to be participating in behavioral therapy. Average pain was reported as a 10/10. After behavioral therapy, he is noted to report a 5/10 or 6/10. He reported he did improve physically and emotionally while performing physical therapy and attending approved group sessions. However, his overwhelming fear of re-injury, as well as lack of solid coping skills were holding him back from successfully achieving the level of performance he needed to return to work. A clinical note dated 11/20/2013 noted the patient had full extension and flexion to 130 degrees, with a mild effusion present. On that date, the patient was given a viscosupplementation injection. The Beck Depression Inventory score was noted on 11/18/2013 to have decreased to 12; and a Beck Anxiety Inventory score of 22 was decreased to 18 after performing individual therapy sessions.

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

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The ODG recommends a chronic pain management program for patients who have chronic pain syndrome with evidence of loss of function that persists beyond 3 months, with secondary physical deconditioning due to disuse or fear avoidance behavior; failure to restore pre-injury function after a period of disability, or with development of psychosocial sequelae that limits functional recovery. However, as the patient is noted to have near normal range of motion and strength of the right knee, and is noted to have improved with individual psychotherapy with minimal symptoms of depression, and is not noted to have been started on a psychotropic medication, and a 12/18/2013 clinical note reported the patient had significantly decreased pain with at least three-quarters of his pain gone, the patient has not failed all conservative treatments therefore, the request for a multidisciplinary pain management program does not meet guideline recommendations. As such, the previous denials of the pain management program are upheld.

## References:

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Pain (Chronic), Chronic pain programs (functional restoration programs).

## 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

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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 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.

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(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.

(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, 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.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less

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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.

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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)