

CASEREVIEW

**8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558**

Notice of Independent Review Decision

[Date notice sent to all parties]: July 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program, Initial 80 Hours 97799

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 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:

10/19/10: Initial Behavioral Medicine Consultation by MS, LCP-Intern and MS, CRC, LPC

03/12/12: Psychological Testing Results by PsyD

5/10/12: Follow-up Evaluation by MD

5/17/12: PPE performed by DC

5/17/12: Evaluation for Chronic Pain Management Program by MS, LPC Intern, LCDC Intern and MS, CRC, LPC

5/17/12: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment

5/24/12: Request for 80 Hours of a Chronic Pain Management Program from Injury Clinic

06/01/12: UR performed by MD

06/06/12: Reconsideration: Request for 80 Hours of a Chronic Pain Management Program by PsyD with Injury Clinic

07/05/12: UR performed by PhD

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a female who was injured on xx/xx/xx while assisting other co-workers with taking off an inflatable whale when she tripped over one of the straps and fell, injuring her lumbar spine, right hip, and right leg. The claimant did not seek treatment until 7/27/10 with her primary care physician. The claimant was treated with physical therapy, MRI's, EMG, 10 individual psychotherapy sessions, 6 biofeedback sessions, and 10 days of work hardening.

On October 19, 2010, the claimant had an initial behavioral medicine consultation with MS, LCP-Intern and MS, CRC, LPC. It was documented that her pain on a daily average was 8/10 and described as having pins and needles sensation across the low back, stabbing pain on the left side of her buttock and groins, with burning pain radiating down the right side of her upper leg. The claimant reported difficulty with specific acts of daily living since the work injury, including household chores, yard work, exercise/playing sports, driving more than 15 minutes, sitting/standing more than 10 minutes, walking for 30 minutes, bending, squatting, lifting/carrying heavy items, climbing stairs, and sexual activity. Diagnosis: Axis I: pain Disorder associated with both psychological factors and a general medical condition, acute, secondary to the work injury. Axis II: no diagnosis. Axis III: Injury to the lumbar spine, right hip, and right leg. Axis IV: Primary support group, economic, and occupational issues. Axis V: GAF=38 (current) Estimated pre-injury GAF: 85+. Recommendation: Based on the initial evaluation it was determined that the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention to facilitate a healthy adjustment and improve her coping with her physical work injury and pain problem. It was recommended the claimant receive immediate authorization for participation in a brief low level of individual psychotherapy for 4 weeks.

On March 12, 2012, the claimant underwent psychological testing with PsyD. Current medications were listed as Cyclobenzaprine hcl 10 mg, Zolpidem tartrate 10 mg, Hydrocodone 7.5/325 mg, Advil 200 mg. I was reported that despite undergoing physical therapy, individual psychotherapy, biofeedback and work hardening, she continued to have moderate severe pain tenderness to her lower back radiating to her right lower extremity. Her daily pain was reported as 9/10. Functionally she reported difficulty with acts of daily living to include: self-grooming, household chores, yard work, cooking, caring for children, exercise/playing sports, driving longer than 15 minutes, standing longer than 15 minutes, walking, bending, squatting, lifting/carrying, climbing stairs, and with sexual activity. She rated her overall functioning at 100% pre-injury and currently at 10%. Interpersonally, she described changes in relationships such as less involved in family activities, less participation in social outings, and felling abandoned by co-workers. She endorsed both initial and sleep maintenance insomnia. Vocationally she was working as a car salesman when she was injured and following recovery plans to return to work selling cars. The claimant scored a 22 on the BDI-II, indicating moderate depression and scored a 29 on the BAI, reflecting severe anxiety. Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition, chronic. Axis II:

no diagnosis. Axis III: Injury to back. Axis IV: Primary support group, economic, occupation problems. Axis V: GAF: current: 59 Estimated pre-injury GAF: 85+. Dr. recommended the claimant participate in a 10 day trial of the chronic pain management program as she had exhausted conservative treatment, yet was negatively impacted by pain and reduced functioning across activities of daily living.

On May 10, 2012, the claimant had a follow-up evaluation with MD who found on physical examination moderate pain and tenderness over her paralumbar musculature with flexion extension. She had pain radiating down her right lower extremity on minimal straight leg raising of 10-15 degrees. She had pain to palpation over her right hip as well. Assessment: 1. Lumbar sprain/strain. 2. Abdominal wall contusion. 3. Right leg neuropathy. 4. Chest wall contusion and pain. 5. Right hip contusion. Plan: Chronic pain management program after doing her FCE and intake evaluations. Discontinued Flexeril and started Diazepam 5 mg. Refilled Hydrocodone and Zolpidem tartrate.

On May 17, 2012, the claimant underwent a PPE. Based on the test results, her current PDL was Sedentary. Required PDL was Medium.

On May 17, 2012, the claimant underwent evaluation for chronic pain management program. It was reported the claimant had completed psychological testing and 10 Individual Psychotherapy sessions, 12 Physical Therapy sessions, injections and was not a surgical candidate. *Lifestyle Changes Related to the Injury:* The claimant reported difficulty with acts of daily living including self-grooming, shopping, household chores, driving, walking, cardio exercises, resistance training, and sexual activity. She further related that any activity made the pain worse. She stated this was a life style struggle and she wants to get better. She also stated there had been changes in relationships to include less involved in family activities and less participation in social outings. *Medication Usage Goal:* The claimant will work with treatment team to titrate medications. *Vocational Status/Plan:* She worked as a salesman for Hyundai and her vocational plan was to return to work at the same position or same like position with different employer due to employer stating the claimant was not rehireable. Her vocational plan was to research three employers hiring in the local area and complete a resume. *Recommendation/Plan:* Approval for a 10 day trail in the interdisciplinary pain rehabilitation program.

On May 24, 2012, a Request for 80 Hours of a Chronic Pain Management Program outlined that the claimant described her pain as chronic, persistent, and intractable at 8/10, with intermittent elevation to 10/10. She was able to report reductions in muscle tension; however, her pain, irritability, frustration, depression, sleep disturbance, forgetfulness, and BDI-2 scores had increased. She also noted maintenance of function in anxiety. It was stated that the claimant's symptoms had proven refractory to conservative levels of care and she had subsequently developed a chronic pain syndrome. She continued to demonstrate functional deficits, marked pain, and sleep disturbance that were impacting her

ability to safely return to work. It was stated she required, as a medical necessity, a more intensive, interdisciplinary pain rehabilitation program in order to resolve active symptoms on a long term basis, dismantle her disabled self-perception, increase her functional tolerances, and propel her toward a safe return to work. A chart outlining her psychological evaluation results with baseline and treatment goals was provided. Interdisciplinary pain treatment components, goals of treatment, chronic pain management program design, interdisciplinary specialties, program philosophy and CPMP day treatment design were all provided.

On June 01, 2012, MD performed a UR. Rationale for Denial: She has not regained her pre-injury functional status even with the substantial number of interventions she has undergone including physical therapy, work hardening, psychotherapy and biofeedback therapy. However, there is no (clear) documentation that there is an absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate where surgery or other treatments would clearly be warranted; the patient exhibits motivation to change, and is willing to forgo secondary gains, and negative predictors of success above have been addressed. Therefore, the medical necessity of the request has not been substantiated.

On July 12, 2012, PhD performed a UR. Rationale for Denial: The patient reported an injury on 05/28/10 and now has complaints of low back pain with radiation down her right lower extremity. Official Disability Guidelines state that chronic pain management programs are recommended where there is access to programs with proven successful outcomes for patients with conditions that have resulted in delayed recovery. There was insufficient documentation submitted to indicate the need for a chronic pain management program at this time. The documentation provided indicated the patient had ongoing complaints of low back pain with radiation down the right lower extremity. The documentation also indicated that the patient had difficulty completing activities of daily living. The documentation also indicated the patient previously underwent 10 sessions of psychotherapy, 6 sessions of biofeedback therapy, and 10 sessions of work hardening; however, biofeedback therapy and work hardening sessions were not submitted for review to indicate efficacy in terms of reducing the patient's pain and increasing function. Additionally, it is unclear based on the documentation why the patient requires a chronic pain management program after completing work hardening. It seems excessive for the nature of injury for the patient to undergo a chronic pain management program after completing work hardening, given that the patient is still noted to have functional deficits and increased pain. I called and discussed this case with Dr., who stated the patient is not doing well enough in work hardening and needs chronic pain management. He said he would fax documents to support this request. At this time, no new clinical has been received. Given the above information, the request for chronic pain management program cannot be substantiated at this time.

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

Denial of 80 Hours of Chronic Pain Management is upheld/agreed upon. Per ODG Pain Chapter #13 “CPM should not be considered a “stepping stone” after a less intensive program.” There is no submitted information regarding previous treatments, particularly work hardening, the dates/hours attended, compliance or progress. There is also no treatment plan regarding the weaning process from current medications. Therefore, the request for Chronic Pain Management Program, Initial 80 Hours 97799 is not found to be medically necessary.

PER ODG:

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 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 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 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. 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](#).

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)**