

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** February 22, 2012

**IRO CASE #:**

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

Chronic pain management program for symptoms related to lumbar spine, 80 hours, as an outpatient

**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 15 years of experience.

**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 or not medical necessity exists for each of the health care services in dispute.

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

- 01-05-12: Behavioral Evaluation Report by
- 01-05-12: Work Capacity Evaluation by
- 01-09-12: Pre-Authorization Request for 80 hours of Chronic Pain Management by
- 01-16-12: UR performed by
- 01-20-12: Request for Reconsideration by
- 01-30-12: UR performed by
- 02-08-12: Letter from

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

This claimant is a male who worked for. On xx/xx/xx, the claimant was crouched under a truck and experienced a strange feeling in his lower back. He received the following diagnostic studies including initial medical evaluation, x-rays, MRI, EMG, FCE, and WCE. His treatment has included rest from work related activities, physical therapy, therapeutic massage, warm/cold compresses, TENS unit, prescribed oral analgesics, 1 counseling session with focus on chronic pain, and anti-depressant medication.

01-05-12: Behavioral Evaluation Report by. During the Mental Status Examination these problem areas were identified: Pain focus, poor coping strategies, vocational concerns, symptoms of depression and anxiety, decreased endurance, and range of motion deficits. On Scores and Clinical interpretation, his pain was perceived to be a 7-8 on a 0-10 scale. His BDI-II his score was a 29 indicating that depression is in the diagnostic range of moderate. On the BAI he scored a 6 indicating that anxiety was in the diagnostic range of mild. On the pain and impairment relationship scale he scored a 76 that is in the elevated range and suggests a strong inclination to perceive and portray himself as being necessarily disabled by any continued pain or discomfort. On the Oswestry Disability Index he scored a 56% which indicated that pain impinges in all aspects of his life, suggesting that positive intervention is required. Diagnostic Impression: Pain Disorder-Associated with Psychological Factor and General Medical Condition, Major Depression Moderate (injury related). GAF current: 65. Treatment plan: It is recommended that symptoms of depression and anxiety are monitored and reviewed by a medical consult. individualized outpatient Chronic Pain Management Program daily plans include interventions to achieve primary goals to include increase appropriate use of medication, decrease intensity of subjective pain, increase ability to manage pain, reduce health care use related to chronic pain syndrome, increase capabilities for return to work, improve functional capabilities by changes objectively documented. Increase his psychological and psychosocial coping capacities to manage individual rehabilitation needs for medically reasonable recovery in occupational and social daily living activities and achieve significant medical care case closure for this compensable injury.

01-05-12: Work Capacity Evaluation by. The claimant's occupation demand as a requires a Heavy PDL. According to the results of the evaluation the claimant is currently performing at a Light PDL.

01-09-12: Pre-Authorization Request for 80 hours of Chronic Pain Management by states that the claimant has chronic pain, functional deficits, and a secondary depressive reaction. He had been treated with anti-depressant medication, he does not have adequate pain and stress management skills, and he needs specific pain and stress management training so that he will be more functional while dealing with his pain on a daily basis. The claimant also needs to undergo significant vocational readjustment. recommended that undergo chronic pain management program to address the psychological component of his injury.

01-16-12: UR performed by. Reason for Denial: Based on discussion with, the current request is recommended for non-certification as medically not necessary or appropriate. suffered a lumbar sprain, date of injury of 04/24/09, which had subsequently resolved. His current symptomatic complaints are due to degenerative disc disease, which is not related to his compensable injury. Therefore, the Chronic Pain Program is not medically indicated or necessary or related to the compensable injury of 04/29/09. Additionally, this individual has not undergone any lower levels of care and therefore the Chronic Pain Program would not be indicated at this time.

01-20-12: Request for Reconsideration by indicated that the claimant has lumbar disc bulges, annular tears, and right L5 radiculopathy. He had been treated with medications, therapy, and physical rehabilitation. Despite the medical necessity, he was not authorized for lumbar ESI as recommended by. No injections or surgery will be provided. He has undergone medication management with the anti-depressant medication Cymbalta. He does not have the pain and stress management skills necessary to adequately function in the presence of constant pain. The claimant is an appropriate candidate for a chronic pain management program to address the significant psychological component of his injury.

01-30-12: UR performed by. Reason for Denial: notes that the claimant sustained an injury to lumbosacral spine and has been treated with physical therapy, medication without resolution. Epidural steroid injection were previously requested but not authorized. The claimant has chronic pain functional deficits, and secondary depressive reaction. He has undergone medication management, antidepressant medication Cymbalta. He does not have the pain and stress management skills necessary to adequately function in the presence of constant pain. He also needs to undergo significant vocational readjustment. Other treatment options had been exhausted and therefore felt he was a candidate for chronic pain management to address a significant psychological component of this injury. The reviewer felt that the a request for epidural steroid injections be resubmitted with a comprehensive history, physical examination outlining radiculopathy that correlates with the claimant's MRI so that epidural steroid injections prior to any reconsideration for a chronic pain management program can be completed. At the present time, however, the request for chronic pain management program for symptoms related to the lumbosacral spine 80 hours was recommended for noncertification.

02-08-12: Letter from stated the claimant has disc protrusions at L4-5 and L5-S1 and electrodiagnostic evidence of right L4 and L5 radiculitis. The medical necessity for the CPMP is also supported by the following: 1. The claimant sustained a compensable injury, which has resulted in chronic pain and chronic functional limitations. 2. Other lower levels of treatment intervention have been exhausted. 3. The claimant needs to learn alternative methods of controlling his pain and diminish his dependence on the analgesics. He is currently taking Hydrocodone and Soma. 4. He has Pain Disorder Associated with Both Psychological factors and a General Medical condition and Major Depressive Disorder, Moderate. 5. He has undergone medication management with the

anti-depressant medication Zoloft. 6. His BDI is 29/63, BAI is 6/63, PAIRS is 76/105, ODI is 56% and GAF is 65. 7. His depressive reaction requires intense treatment through the multifaceted behavior and chronic pain management program in order to adequately affect his status. 8. He needs specific pain and stress management training so that he will be more functional while dealing with his pain on a daily basis. 9. He has significant functional deficits. He requires assistance with many of his regular activities of daily living. Physical activity exacerbates the pain, rendering him incapable of tolerating sustained activity. 10. Significant vocational readjustment is required.

### **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. Submitted clinical are lacking specific details and therefore, do not meet ODG/clinical criteria outset by the ODG Pain Chapter: 1(g) There is confusion regarding current medication with notation of treatment with Cymbalta and/or Zoloft. There is also no notation of any other prescribed over the counter pain medication-of particular relevance would be use or absence of narcotic analgesics. (2) There are no details regarding lower levels of care: the number of previous PT visits or work conditioning, when they took place relative to the injury, attendance, compliance, progress. 3(a) There is no submitted current physical exam. 3(d) There are no specifics regarding vocational issues such as whether the job of injury is available or plans/motivation to return to the same type of work. (9) Given great than 24 months since injury/of disability, outcomes/goals are not clearly identified.

#### **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)**