

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: September 17, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program – 80 Hrs Initial Trial 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:

11-21-11: Initial Behavioral Medicine Consultation.
07-31-12: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment
08-01-12: Assessment/Evaluation for Chronic Pain Management Program
08-07-12: Psychological Assessment Report
08-16-12: CPM History and Physical dictated
08-16-12: Physical Performance Evaluation dictated
08-17-12: Pre-Authorization Request for Chronic Pain Management Program – 80 hours Initial trial – Outpatient
08-22-12: UR performed
08-27-12: Reconsideration: Chronic Pain Management Program
08-31-12: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that sustained a work-related injury to his low back on xx/xx/xx while performing his customary duties at the time of the injury. He was removing boxes when he encountered a very heavy one and felt a sharp pain in his low back, at which point he told his supervisor who was right there with him. He was sent and given pain medications and later given some physical therapy.

11-21-11: Initial Behavioral Medicine Consultation History of Presenting Problem and Resulting Treatment: MRI of lumbar spine without contrast from 8/11/11 revealed disc desiccation and small disc extrusion into the right lateral recess and right neural foramen at the L5-S1 level in contact with the right L5 and right S1 nerves with minimal displacement of the right S1 nerve estimated at 5mm in depth. Claimant underwent a transforaminal epidural injection at L5-S1 on the right on 10/11/11 with minimal benefit. Per available medical records, while a patient is a possible surgical candidate for a discectomy, claimant desires to attempt a functional restoration program with the goal of avoiding surgical intervention. has required that the claimant be evaluated for participation in a Work Hardening Program. Present Medication: 2 OTC Aleve each morning. Patient's Description of Pain: Claimant self rates his pain on a scale as a 6/10. He rates his various pain levels as follows: with medication: 4, without medication: 7, at its worst: 10, and his average daily pain as 5/10. HE describes his pain as aching in his low back, above his right hip, which becomes sharp stabbing pain if he tries to climb steps. He also noted an aching pain on the left side of his low back above the hip. The claimant reported an aching pain in his right hip (along the side and in the front) and in his groin with an occasional pricking pins sensation mainly in his left leg. When quantifying the level of interference his pain has on recreational, social and familial activities, he rates these all as 8/10; for pain interference with normal activities as 8/10; and change in ability to work as 9/10. Per claimant report, he continues working with light-duty restrictions, which include: limited periods of sitting, standing and walking along with no bending, no squatting, and no lifting over 5 pounds. However, claimant noted that he really is not able to do "much work at all" between his pain, decreased physical functioning, and work restrictions. Claimant rates his level of overall functioning in life prior to the injury at 90% and rates his current level of functioning at 60%. The claimant endorses sleep maintenance insomnia (8 or more awakenings per night and early morning awakening). Multiaxial Diagnosis: Axis I: 307.89, Pain Disorder associated with both psychological factors and a general medical condition, Acute; Axis II: V71.09, no diagnosis; Axis III: Injury to low back – See medical records; Axis IV: Problems related to personal physical injury; occupational and economic problems; Axis V: GAF – current: 59; Estimated pre-injury: 81+. Treatment Recommendations/Summary: Given the information gathered in this intake, the claimant would be an excellent candidate for the Work hardening Program since the combination of intensive physical rehabilitation, work stimulation, and didactic group psychotherapy services offered in this program may facilitate resolution of the claimant's functional deficits and mood and sleep disturbances, thus facilitating a safe and successful return to work.

08-01-12: Assessment/Evaluation for Chronic Pain Management Program dictated. Multiaxial Diagnosis: Axis I: 307.89, Pain Disorder associated with both psychological factors and a general medical condition, Chronic, 296.22 Major Depressive Disorder, Single Episode, Moderate; Axis II: V71.09, no diagnosis; Axis III: Injury to low back – See medical records; Axis IV: Primary Support Group, Occupational and economic problems; Axis V: GAF – current: 55; Estimated pre-injury: 85+. Treatment Recommendation/Plan: The claimant has participated in a course of physical therapy, received an epidural injection at L5-S1 (10/11/11) minimal benefit. Per available records, while the claimant is a possible surgical candidate for discectomy, the claimant desires to attempt a functional restoration program with a goal of avoiding surgical intervention. The claimant completed 30 days of Work Hardening Program in March 8, 2012 and participated in 6 individual counseling sessions with significant emotional gains. We concur recommendation that the claimant participate in the chronic pain management program after exhausting conservative treatment. Currently, he is negatively impacted by pain and reduced functioning across activities of daily living. He has responded positively to past treatment, but has failed to restore his functioning (FABQ-W 36, FABQ-PA 15). He will require an interdisciplinary chronic pain management program in order to reduce his pain and fear avoidance behavior's while improving his physical capabilities and functioning in order to propel this claimant toward a safe return to work and facilitate medical case closure.

08-07-12: Psychological Assessment Report dictated. The claimant reports his average daily pain as 8/10. His pain with limited activity is at 8/10 and with activity is at a 9/10. When he was asked to quantify the level of interference his pain has on his recreational, social, and familial activities, he rates these all as 9/10; for pain interference with normal activities as, 8/10; and change in ability to work, 10/10. Functionally, the claimant reports difficulty with acts of daily living to include: self-grooming/self care (bending over hurts his back), performing household chores due to pain in his lower back and right hip), engaging in sports (basketball), driving more than 30 minutes (then he must take a break and stand and stretch), sitting for more than 30 minutes, standing for a prolonged period, walking, bending, squatting, climbing stairs (at home he climbs 3 steps and his right hip aches and burns), and lifting/carrying objects weighing more than 10 pounds (increases the pain-ache in his shoulders). The claimant explained these difficulties noting that he “really can’t do much now.” He noted having slow and careful while grooming/dressing himself. He lamented that he no longer goes to the grocery store and is unable to play with his grandchildren like he used to. As a result, he has “a pretty boring life now.” rates his level of overall functioning in life prior to the injury at 100% and rates his current level of functioning at 45%. Claimant’s vocational plan at this time is to return to work in a different position and different employer; however he is unsure of what type he could perform due to his physical limitation. Multiaxial Diagnosis: Axis I: 307.89, Pain Disorder associated with both psychological factors and a general medical condition, Chronic, 296.22 Major Depressive Disorder, Single Episode, Moderate; Axis II: V71.09, no diagnosis; Axis III: Injury to low back – See medical records; Axis IV: Primary Support Group, Occupational and economic problems; Axis V: GAF –

current: 55; Estimated pre-injury: 85+. Treatment Recommendation/Plan: Treatment Recommendation/Plan: We concur recommendation that the claimant participate in the chronic pain management program after exhausting conservative treatment. Currently, he is negatively impacted by pain and reduced functioning across activities of daily living. He has responded positively to past treatment, but has failed to restore his functioning (FABQ-W 36, FABQ-PA 15). He will require an interdisciplinary chronic pain management program in order to reduce his pain and fear avoidance behavior's while improving his physical capabilities and functioning in order to propel this claimant toward a safe return to work and facilitate medical case closure.

08-16-12: Physical Performance Evaluation dictated. Clinical Assessment: Claimant was diagnosed with: 847.2(sprain lumbar region). Job description lift category: Medium Work. Assessments: The claimant is currently unable to safely perform his job demands based on comparative analysis between his required job demand and his current evaluation outcomes.

08-16-12: CPM History and Physical dictated. Chief complaint: Low back pain. Claimant's current medications include: Lisinopril 5 mg daily, Bayer aspirin 325 mg daily, Naproxen 500 mg BID PRN. Impression: 1. (4 or more of the 8 D's from AMA 4th Edition Definition of "chronic pain syndrome": Duration (pain persistent beyond 3-4 months post incident), Diagnosis dilemma (extensive evaluations by multiple physicians with ambiguous findings), Dependence (...on physicians for extensive medical care), Disuse (physical deconditioning often with inhibition of function or fear avoidance), Dysfunction (withdrawal from social, disability from work, restrictions of activity or daily living). 2. Lumbar sprain and disc herniation of L5-S1. 3. MRI abnormalities. 4. Chronic pain syndrome. Plan: 1. Would recommend chronic pain management program for the claimant. One of the goals would be to reduce dependence on pain medications. 2. Work status for 73 reviewed and filled out. 3. I will recheck claimant in 2 weeks. 4. Advised to follow up with primary care physician for blood pressure management.

08-17-12: Preauthorization Request for 97799 Chronic Pain Management Program – 80 hours initial trial – Outpatient. The patient is currently at Light PDL; his required PDL is Medium. Claimant's injury related medications include: Lisinopril 5 mg daily, Bayer aspirin 325 mg daily, Naproxen 500 mg BID PRN, Aleve 220 mg (OTC) 1-2 PRN. Summary: Please recall that prior treatment modalities have failed to stabilize the claimant's psychological distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. is approximately 1 year 1 month status post injury. His pain is chronic, persistent, and intractable at 7-9/10, depending on his level of activity. Conservative care has not been sufficient to extinguish his pain or increase his functional tolerances such that he could successfully return to his previous developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce the claimant's pain experience, develop self-regulation skills, and facilitated a timely return to the work force. Thus, authorization for 80 hours in a Chronic Pain

Management Program appears reasonable and medically necessary for any lasting management of his pain symptoms and related psychological problems, as it is recommended treatment of choice for patients with chronic pain syndrome.

08-22-12: UR performed. Reason for denial: Based on the clinical information provided, the request for chronic pain management program 80 hours initial trial is not recommended as medically necessary. Per telephonic consultation on 8/22/12 at 11:45 am cst, they are trying to avoid surgery. The claimant completed a work hardening program at the end in 2011. Current evidence based guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. The patient did not show significant progress with individual psychotherapy. Given the lack of progress with treatment to date, the request is not indicated as medically necessary.

08-31-12: UR performed. Reason for denial: A peer to peer was attempted but was not successful on 2 attempts on separate days. The claimant is currently 1 year, 1 month post injury. The records indicate the claimant's job is a Superior for Order takers/pullers at Walmart. According to Dictionary of Occupational Titles (DOT) revised fourth edition the claimant's job requiring a Sedentary PDL, which the claimant should be capable of performing already without the need for the current request. The employer has not provided a detailed job description or a verified job to return back for this claimant. The patient completed a work hardening program at the end of 2011. The recent appeal indicates the claimant completed 10 visits of Work Hardening Program in March of 2012. The evidence based guidelines does not support repeating the same or similar program for the same work injury. The guidelines do not support using a Chronic Pain Program as a stair step program following a lower level of care program, such as following a work conditioning or Work Hardening Program, such as the current request for this claimant following the completion of a work hardening program. There is no evidence the claimant was returned to normal or modified work duties following the completion of the work hardening program in 2011 or in March of 2012. The negative predictors have not been addressed. The claimant has mild anxiety and depression on the last psych evaluation performed. Documentation that the claimant is willing to change has not been provided. There is no evidence the claimant has failed all other treatment methods. There is no evidence of attempts to return claimant to modified work duties or full duty work status prior to the current request. A return of work duties has the best long term outcome per ODG., even if the claimant return to, nor is there a job description/job demand per the employer to support the current request. The claimant does not meet the ODG criteria for the current request. The current request is not consistent with the evidence based guidelines, ODG. Based on the documentation provided, objective and subjective findings this request is not medically reasonable and necessary. Non-Authorization is advised.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Denial of 80 hrs of Chronic Pain Management Program is upheld/agreed upon. Several ODG Pain Chapter criteria are not met. There is no information submitted

regarding progress or lack of progress of previous rehabilitation – more specifically work hardening “at the end of 2011” and again in “March 2012.” There is mention of goal to reduce dependence on pain medication, but no treatment plan regarding medication. And there is no notation of whether there is a job to return to and therefore there is no plan regarding return to function. The request is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for Chronic Pain Management Program – 80 Hrs Initial Trial 97799 is denied.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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).</p> <p>(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.</p> <p>(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</p>
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	<p>interventions and planned duration should be specified.</p> <p>(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.</p> <p><u>Inpatient</u> 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.</p>
<p>Chronic pain programs, early intervention</p>	<p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <ul style="list-style-type: none"> (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) Risk factors are identified with available screening tools or there is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions. (f) Evidence of psychosocial barriers that make return to work unlikely. (g) Loss of employment or evidence of partial disability involving ability to perform only "part-time" work or work with "light-duty" restrictions for greater than 4 months. (Mayer, 2003) (Gatchel, 2003) For general information see Chronic pain 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)**