# CASEREVIEW

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** March 21, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Chronic Pain Management Program – Additional 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 in 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:

☒ Overturned (Disagree)

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:**
08/24/12: Health and Behavioral Reassessment
12/13/12: Physical Performance Evaluation
12/18/12: Assessment/Evaluation for Chronic Pain Management Program
12/18/12: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment
12/31/12: History and Physical
12/31/12: Psychological Testing and Assessment Report
01/08/13: Preauthorization Request
01/10/13: UR performed for CPM initial 80 hours
02/05/13: Physical Performance Evaluation
02/06/13: Reassessment for Chronic Pain Management Program Continuation
02/12/13: Continuation: Chronic Pain Management Program Preauthorization Request
02/15/13: UR performed

02/26/13: Reconsideration: Continuation Chronic Pain Management Program Preauthorization Request
03/04/13: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The claimant is a female who was injured on xx/xxxx. She had been returning from break on a rainy day and slipped on the marble floor upon entering the building, causing both legs to go out from underneath her and she landed on her low back and buttocks. She had complaints of low back and right lower extremity pain. According to the records, she underwent a MRI of the lumbar spine on 02/02/12 which revealed Grade 1 spondylolisthesis at L5-S1, a 5 mm broad right paracentral and foraminal disc protrusion and moderate degree of degenerative facet hypertrophy with the disc impinging on the thecal sac, right L5 and S1 nerve roots causing severe right foraminal and lateral recess stenosis; a 3 mm posterior disc protrusion at L4-L5 which mildly impinges on the thecal sac with moderate lateral recess stenosis, a 2 mm posterior disc protrusion at L2-L3 and 3 mm posterior central disc protrusion at L1-L2. An EMG of the lower extremities on 02/16/12 revealed radiculopathy at L5 and S1 on the left. X-ray of the lumbar spine on 02/09/12 revealed partial sacralization of the L5 vertebra, Grade 1 Retrolisthesis at L4-L5, moderate degenerative facet joint hypertrophy at L4-L5 and L5-S1, mild degenerative facet joint hypertrophy at L3-L4. The claimant underwent an EST with no significant improvement. On 06/19/12, the claimant underwent an anterior lumbar interbody fusion at L5-S1 with posterior lumbar decompression, posterolateral fusion and pedicle screw instrumentation at L5-S1. She underwent post-op physical therapy.

On August 24, 2012, the claimant was reassessed to assess her emotional status and to determine her suitability for some level of behavioral medicine treatment and/or return to work program. Current medications: Floricet/codeine 50-325-40-30mg, Soma 350mg, Synthroid 175mcg, Effexor 75mg, Ibuprofen 200mg. Pain level: 7/10 with medication, without medication 9/10. She described the pain as an aching pain across her low back with shooting, electrical pains down the back of her right leg, primarily at night after she has been moving all day. She also noted sporadic numbness down the back of her right leg. Work status: She was off work and was terminated by her employer for failure to return to work within 12 weeks of her injury. Lifestyle changes: The claimant reported these difficulties following surgery: performing household chores, caring for her family members, driving for more than 20 minutes, sitting for more than 20 minutes, standing for more than 10 minutes, walking for more than 15 minutes, bending, squatting, crawling, climbing stairs, lifting/carrying objects, and engaging in sexual activity. Basically she cannot remain in any one position longer than 10 minutes and then has to reposition. According to her, her overall functioning prior to the injury was 100% and rated her current level at 50% (which was up from the 30-40% she noted prior to surgery). Interpersonally, she stated she was less involved in family activities and no longer able to participate in social outing or entertain others as she did prior to the injury. Mental Status: Her mood was anxious and dysthymic while her affect was constricted and lethargic. She did exhibit cognitive distortions

including: fortune telling, catastrophizing, and “should” statements. BDI-II score: 12 indicating minimal depression. BAI score: 21 reflecting mild anxiety. FABQ-W = 21 and FABQ-PA=12 which showed non-significant fear avoidance of work and physical activity in general. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic. Anxiety disorder, NOS. Axis II: No diagnosis. Axis III: Injury to low back. Axis IV: Problems related to personal physical injury; economic and occupation issues. Axis V: GAF – Current: 55; Estimated pre-injury: 82+. “We would determine that the work accident pain and ensuing functional limitation have caused this patient’s disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. The patient appears to have been functioning independently prior to the work injury of 12/14/11.” Requested Service: Individual Psychotherapy 1x6 weeks.

On December 13, 2012, the claimant underwent a Physical Performance Evaluation. The copy quality of the report is poor. Assessments: The evaluee is unable to perform in their regular job duties at this time. Current level was Sedentary, her required PDL is Light. Recommendations: Referral to a functional restoration program.

On December 18, 2012, the claimant underwent an evaluation for chronic pain management program by, LPC and, PhD. Baseline assessment scores were as follows: FABQ-W=16, FABQ-PA=4, BDI-II=13-=minimal, BAI=17=moderate, Oswestry Disability Index was 60%=severe. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic. Anxiety disorder, NOS. Axis II: No diagnosis. Axis III: Injury to low back. Axis IV: Problems related to personal physical injury; economic and occupation issues. Axis V: GAF – Current: 55; Estimated pre-injury: 82+. Vocational Status/Plan: The patient is off work and was terminated by her employer for failure to return to work within 12 weeks of her injury. While she is quite motivated to return to work as soon as possible, she is not yet sure of her physical tolerances for doing so. Recommendation/Plan: We concur recommendation that the patient participate in Chronic Pain Management Program as Ms. has exhausted conservative treatment including lumbar fusion surgery, 30 sessions of post-surgical physical therapy, and 10 sessions of individual psychotherapy. She does not qualify for Work Hardening given the Physical Demand Level of her job.

On December 31, 2012, the claimant was evaluated for low back pain with radiation of pain to the right leg. On physical examination lumbar straight leg raising was positive at 30 degrees on the right. There was pain on flexion at 45 degrees and extension at 30 degrees. Reflexes were normal and there was no muscle spasm. Her gait was normal and there was mild compression pain over the lumbar spine. There were no motor or sensory deficits noted. Impression: Lumbar disc disease with radicular pain to right leg – postoperative. Plan: Functional restoration program.

On February 5, 2013, the claimant underwent a Physical Performance Evaluation. The copy quality of the report is very poor. Assessments: The evaluee could not completely perform in the 10 to 20 pound light category on an occasional basis on the PILE lifting protocol. Therefore, the evaluee must be listed in the light lifting category and should be restricted to no more than 15 pounds of dynamic lifting on an occasional basis and 5 pounds on a frequent basis. The evaluee is unable to perform their regular job duties at this time which requires Light PDL (10-20lbs). Recommendations: Continued participation in the chronic pain management program is recommended.

On February 6, 2013, the claimant underwent a re-evaluation for continuation of a chronic pain management program. Assessment scores were as follows: FABQ-W= Baseline=16, Current=32; FABQ-PA=Baseline=4, Current=4; BDI-II=Baseline=17-moderat, Current=11-mininal; BAI=Baseline=13-mild, Current=11, mild; Oswestry Disability Index baseline was 60%=severe, current 30%=moderate. Current Medications: Hydrocodone 7.5-500mg, Mobic 15mg, Effexor 75mg, Xanax .5mg, and Synthroid 175mg. It was noted the claimant discontinued Soma and decreased usage of Hydrocodone from every 4 hours prior to CPM to evening usage following her day of participating in CPM. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic. Anxiety disorder, NOS. Axis II: No diagnosis. Axis III: Injury to low back. Axis IV: Problems related to personal physical injury; economic and occupation issues. Axis V: GAF – Current: 60; Estimated pre-injury: 82+. Vocational Status/Plan: Her plan is to return to a position in the Medical Billing and Coding field. Treatment Recommendation/Plan: We concur with recommendation that the patient continue to participate in Chronic Pain Management Program. While her pain level has increased with her participation in treatment, she notes that is has been a tremendous help for her body. However, she remains concerned about the knot on the right side of her low back near her buttocks which she feels is “working against” her. Ms. notes that as she has become more active, the pain has significantly increased; she is hopeful that with additional days in CPM, that her muscles will become more conditioned and that her pain will decrease. She reports that she is now engaging in more ADLs (e.g. mopping and sweeping) which she had been avoiding prior to participation in CPM. She also states her anxiety has lessened/improved while in the program and notes that her participation in CPM has helped her to start “reintegrating with the world”. She also reports attempting to use other pain relief tools/techniques (e.g. ice, warm baths, abdominal breathing, etc.) prior to taking Hydrocodone. It was felt that the claimant is highly self-motivated and compliant who is quite active on the rehabilitation floor and eagerly does her part to recover from her injury as she is demonstrably driven to return to work. However, the patient notes that she wants to be able to function upon her return to work, and does not believe that she would be able to do so at the present time. Recommendation is for continued participation in the CPM.

On February 15, 2013 performed a UR. Rationale for Denial: I discussed this case and requested procedure. The clinical indication and necessity of this procedure could not be established. There are no submitted medical notes associated with this program. There is no documentation that a medical director or other physician has provided regular care and/or medical supervision for this patient's program. the patient was seen following the completion of the 10 sessions, on 2/12. when the patient then saw he opined that there was an "acute exacerbation of right gluteal pain," inferred an exacerbation of piriformis syndrome, and started the patient on Depo Medrol. Despite any medical indications for this, such an event is likely a clear reinforcement of pain behavior, which the program would conceivably be attempting to extinguish. Periodic increases in pain complaint or inference of pain "flare-ups" are generally a function of pain behavior under the control of psychosocial influences and/or learning in this type of patient. That such have not been assessed, the behavior explicated, and appropriate behavior treatment plan promulgated suggests that further treatment in the program is not indicated. Thus far in the program there is no documentation of improvements in physical output parameters. Baseline and current exercise performance values are not provided, with an "XX" in the supplied data fields. The offered "isometric strength" measurements are irrelevant; this is not functioning. There is no recorded clinically meaningful change in functional status, ADL, or change functional tolerances. Pain behavior has not been recorded or addressed. Despite the patient's obesity, there is no record of progress in weight loss; and the provider could not actually provide the patient's weight at this time. Specifics of any social functioning external to the program are not tracked or recorded. Vocational preparation has not been addressed; and any medical work restrictions are unknown to the provider. The measurement of short-term progress utilizing "pain levels" is not clinically meaningful. I am not able to establish a basis that continuation of this treatment is both reasonable and necessary at this time.

On February 26, 2013, a reconsideration of continuation of CPM was submitted in which it was indicated that the claimant was followed during the program and was seen on 01/29/13 and 02/12/13. Her case was also discussed in Team conference meetings on 01/29/13, 02/05/13, 02/12/13, and 02/19/13. Some Post-Injury ADLs Alterations were also documented, such as increasing walking from 15 minutes to 30 minutes following 10 days of CPM, Socializing Functioning with family and friend prior to CPM was only by phone or text and she avoided social invitations out due to pain and anxiety. After CPM she was able to attend a stock show with her family and did well with anxiety. Before CMP she was noted to just walk on the treadmill, following CPM she was enjoying working out in the program and was pushing herself to stay active; enjoyed NIA & Yoga. She is wanting to do a 5K walk in late Feb. It was also reported that weight loss was not one of the program goals. The claimant is indicated to be overweight, but not morbidly obese. She is 5 feet 7 inches with a weight of 215 pounds (BMI of 33.2).

On March 4, 2013, performed a UR. Rationale for Denial: The request for 80 additional hours of CPMP is not established as medically necessary. The claimant

has already completed 10 prior sessions to date. ODG states that treatment is not suggested for more than 2 weeks without evidence of compliance and significant demonstrated efficacy is documented by subjective and objective gains. FABQ scores were equivocal. BAI was modestly improved from 13 to 11. There was no documentation of BDI II. There was no documentation of medication titration record. There was no documentation of attendance record. Functional capacity evaluation data was submitted. However, the aforementioned was illegible due to poor copy quality. As such, the request is inconsistent with evidence-based guidelines.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
Denial of 80 additional hours of Chronic Pain Management is overturned/disagreed with. After 10 sessions (80 hours), submitted clinical information does demonstrate subjective and objective gains with residual functional deficits. Physically/Functionally improved from sedentary 5 pounds to Sedentary-Light 5 to 15 pounds with goal of Light 10 to 20 pounds, and decreased medications, and improved psychometric parameters (BDI from 17 to 11, BAI from 13 to 11, GAF from 55 to 60). All modest gains, but gains nonetheless with room to improve. Submitted documentation supports that the request for Chronic Pain Management Program – Additional 80 Hours 97799 meets ODG criteria and therefore, is 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)**