

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: August 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Chronic Pain Management Program 5 x Wk x 2 Wks (80 hours)

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

The reviewer is a licensed psychologist with 25 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:

10/23/12: Initial Behavioral Medicine Consultation
03/13/13: Assessment/Evaluation for Work Hardening Program
03/18/13: Work Hardening Program Preauthorization Request
03/18/13: Physical Performance Evaluation
04/03/13: Physical Performance Evaluation (illegible)
04/18/13: History and Physical
04/19/13: Referral
04/29/13: Assessment/Evaluation for Chronic Pain Management Program
04/29/13: Chronic Pain Management Interdisciplinary Plan and Goals of Treatment
05/01/13: Psychological Testing and Assessment Report
05/08/13: Request for 80 Hours of a Chronic Pain Management Program
05/16/13: Followup Visit
05/24/13: Physical Performance Evaluation (illegible)
05/31/13: Reassessment for Chronic Pain Management Program Continuation
06/04/13: Continuation: Chronic Pain Management Program Preauthorization Request

06/10/13: Clinic Referral Form
06/13/13: UR performed
06/15/13: History and Physical
06/21/13: Reconsideration: Continuation Chronic Pain Management Program
Preauthorization Request
07/21/13: UR Performed
Patient Face Sheet

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured when he lost his balance on xx/xx/xx.

03/13/13: The claimant was evaluated for screening for participation in the Work Hardening Program. It was noted that he had exhausted conservative treatment yet continued to struggle with pain and functional problems that posed difficulty to his performance of routine demands of living and occupational functioning. It was recommended that he participate in the Work Hardening Program in order to increase his physical and functional tolerances and to facilitate a safe and successful return to work.

03/18/13: A preauthorization request for Work Hardening Program from Injury 1 notes that the claimant showed modest improvement with outpatient physical therapy modalities.

03/18/13: The claimant was evaluated. It was assessed that the claimant could not safely perform his job demands based on comparative analysis between his required demands and his current evaluation outcomes. It was recommended that he continue with Work Hardening Program.

04/18/13: The claimant was evaluated. On musculoskeletal exam, he had moderate tenderness diffusely over the thoracic spine. There was pain on rotation to the left and to the right greater than 30 degrees. There was no spasm present. Impression was that the claimant had pain beyond 3-4 months post incident, substance dependence on prescribed or other medications, dependence on physicians for extensive medical care, and withdrawal from social, disability from work, restrictions of activity, or daily living. The plan was for CPM program.

04/29/13: The claimant was evaluated. Tests: FABQ-W 42, FABQ- PA 24, BDI-II 28, BAI 34, ODI 78%. His medication list included Amitriptyline, Flexeril, Motrin, and Tramadol. He was diagnosed with pain disorder associated with both psychological factors and a general medical condition, chronic and major depressive disorder, single episode, severe without psychotic features. GAF 59. It was recommended that he participate in the Chronic Pain Management Program.

05/01/13: The claimant was evaluated. It was noted that he had participated in physical therapy. He also participated in six individual psychotherapy sessions and failed a 10-day trial in the Work Hardening Program. On clinical review, he reported his average daily pain as 9/10. He reported difficulty with acts of daily

living. He rated his overall functioning at 45%. He endorsed both initial and sleep maintenance insomnia. It was noted that he would like to go back to work at a similar job after recovery. Testing: BDI-II 26, moderate depression. BAI 35, severe anxiety. FABQ-W 42, FABQ-PA 24. It was recommended that he participate in the Chronic Pain Management Program.

05/16/13: The claimant was evaluated for mid back pain. On exam, he had mild to moderate thoracic pain on rotation to the left and right. There was minimal pain on compression over the upper thoracic area. Reflexes were normal. No other motor or sensory deficits were noted. recommended that he continue with chronic pain management.

05/31/13: The claimant was evaluated for continued participation in the Chronic Pain Management Program. FABQ-W 42, FABQ-PA 24. ODI 74%. The claimant reported that the chronic pain management program had been helpful at managing his pain and stressors related to the work injury. It was noted that over the past few weeks, his stressors had increased; however, he had been able to at least maintain and in some areas improve his ability to cope with the negative symptoms associated with his stressors. It was recommended that he participate in the Chronic Pain Management Program.

06/04/13: A request for continuation of Chronic Pain Management Program noted that the claimant was recently authorized for a 10-day trial of an interdisciplinary Chronic Pain Management Program, which he had almost completed. "Based on progress made within the 10 day trial of the program, we are requesting 80 additional hours of the Chronic Pain Management Program for Mr.." Following 10 days of the program, a chart noted that pain, irritability, nervousness, and forgetfulness was maintained and frustration, muscle tension, depression, sleep problems, and BDI-II were increased. His FABQ was unchanged. His ODI went from 78% to 74%. BAI from 34 to 36. BDI-II 28 to 36. On PPE performed on 05/24/13 revealed the following deficit areas for improvement: Push went from 13.5 to 21.2, max frequent lift from 4 to 7. He was previously at sedentary; he is currently at sedentary; his required PDL is heavy.

06/13/13: UR performed. REVIEWER COMMENTS: The patient's mechanism of injury was when he lost his balance, injuring his neck and shoulder. The patient's medications include Amitriptyline, Flexeril, Motrin, and Tramadol, with titration of Tramadol the focus of the program. Diagnostic imaging was not stated. Other healthcare services were noted to be physical therapy as well as medication management as well as functional capacity evaluation. The current requires is for additional chronic pain management program 5 times a week x 2 weeks for 80 hours. The patient is a male who reported a work-related injury on xx/xx/xx. Per documentation submitted for review, the patient sustained an injury to his neck and shoulder and has recently undergone a trial of 10 days interdisciplinary chronic pain management program. Per clinical note dated 06/04/13, he was noted to have had previously participated in 6 individual psychotherapy sessions and failed 10 days trial of work hardening program and also undergone psychological testing. The patient is noted to continue with marked pain and

unresolved functional problems that are associated with reliance on significant others to complete ADLs and unemployment. On initial entrance to the chronic pain management program, the patient rated his pain as 9/10 on visual analog scale, with current rating maintained. Irritability was noted to be 6 and is maintained. Frustration was noted to be a 7 and has increased to 8, as well as muscle tension has increased, nervousness has been maintained, depression has increased, sleep problems have increased, forgetfulness has been maintained. BDI-II in depression has increased from 26 currently to 36. Fear avoidance beliefs about work have remained the same; fear avoidance beliefs about physical activity have remained the same. Distraction has increased on the coping strategies questionnaire; ignoring pain has decreased; distancing from pain has increased, the coping self-statements have increased and praying has increased. ODI has decreased from initial evaluation of 78 percent to currently at 74 percent, and BAI has increased from 34 to 36. The patient's pain, irritability, frustration, muscle tension, anxiety, depression, and sleep problems have all increased as well as average hours slept has increased from 5 to 6. The patient was noted to have increased his push from 13.5 pounds to 21.2 pounds, and maximum frequent lift on initial evaluation was 4 pounds, currently at 7 pounds. He was previously at a sedentary PDL and currently is noted at sedentary PDL, and his required PDL is heavy. The patient is noted to be independent with washing hair and body, brushing teeth, and wearing shirts. Based on the documentation submitted for review, the patient has not demonstrated significant subjective or objective gains with the previous 80 hours of the chronic pain management program. Psychosocial stressors have continued to increase with little improvements noted in function. The patient still remains as sedentary PDL, and it is noted that his required PDL is heavy. Therefore, it is unclear as to how an additional 2 weeks of chronic pain management program would benefit the patient as the patient had limited functional benefits with the previous 80 hours of interdisciplinary pain rehabilitation program. Therefore, the current request would not indicate necessity.

06/15/13: The claimant was evaluated. On physical exam, he was in moderate distress due to neck pain and low back pain. He was wearing a C-collar and was exceedingly stiff. He walked with a cane. Cervical range of motion was essentially nil at about 10 degrees in either direction with pain. His extension and flexion were zero. Thoracic spine was tender throughout. Gait was antalgic. IMPRESSION: Thoracic strain. PLAN: Request another 10 days of chronic pain management program for thoracic spine.

07/11/13: UR performed. REVIEWER COMMENTS: Initial request for additional chronic pain management program x 80 hours was non-certified noting that the patient has completed a 10-day trial of a CPMP, 6 IPT sessions and 10 days of work hardening program. The patient's pain rating is unchanged at 9/10. Irritability remains 8, frustration increased from 7 to 8, muscle tension has increased, nervousness is the same. Depression has increased, sleep problems have increased. BDI increased from 26 to 36. FABQ scores are unchanged. Oswestry has decreased from 78 percent to 74 percent. BAI increased from 34 to 36. PDL remains sedentary with required PDL of heavy. Reconsideration dated

06/21/13 indicates that the patient reports increasingly frustration navigating the workers comp system. Per telephonic consultation, the patient has had good attendance and is not taking any narcotic medications. There is insufficient information to support a change in determination, and the previous non-certification is upheld.

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

The previous adverse decisions are upheld. The UR performed on 06/13/13 was correct in concluding that the patient has not demonstrated significant subjective or objective gains with the previous 80 hours of the chronic pain management program. ODG states that neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Therefore, the claimant does not meet ODG criteria, and the request for Additional Chronic Pain Management Program 5 x Wk x 2 Wks (80 Hours) is not medically necessary.

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:</p> <p>(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;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected;</p> <p>(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</p>
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	<p>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 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).</p>
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	<p>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 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>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**