

# CASEREVIEW

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## Notice of Independent Review Decision

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

### IRO CASE #:

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

Additional 80 hours of Chronic Pain Program

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

The Reviewer is a Licensed Psychologist with over 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:

03/19/13: Physical Performance Evaluation

04/12/13: Physical Performance Evaluation

04/15/13: Reassessment for Chronic Pain Management Program Continuation

04/25/13: Continuation: Chronic Pain Management Program Preauthorization Request

04/30/13: UR performed

05/08/13: Reconsideration: Continuation Chronic Pain Management Program Preauthorization Request

05/29/13: UR performed

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while performing his customary duties whom he had worked for approximately 2 months. The doors to fall onto the patient's right shoulder and side. He injured his right wrist, right ribs, right leg and low back. The claimant has undergone lumbar ESIs, right shoulder

surgery and right hand/wrist surgery. He completed 24 post-operative physical therapy sessions. Lumbar L3-S1 fusion has been recommended, however the compensable injury has been limited to lumbar sprain/strain. He has also participated in 10 days Work Hardening program and 4 individual psychotherapy sessions. He continues to have pain in his back and radiates into both of his legs but not below the knees.

On March 19, 2013, the claimant underwent a Physical Performance Evaluation where he tested in the Medium PDL category with lifting restrictions of no more than 35 pounds of dynamic lifting on an occasional basis and 25 pounds on a frequent basis.

On April 12, 2013, the claimant underwent a Physical Performance Evaluation where he tested in the Heavy PDL. He was able to lift 40 pounds on an occasional basis and 30 pounds on a frequent basis.

On April 15, 2013, the claimant was evaluated regarding continued participation in the Chronic Pain Management Program. Results of Assessments Utilized: FABQ-W: Baseline-39, 3/20/13-38, 4/15/13-37; FABQ-PA: Baseline-24, 3/20/13-19, 4/15/13-21; ODI: Baseline-70% cripple, 3/20/13-42% cripple, 4/15/13-56% cripple; BAI: Baseline-5 minimal, 3/20/13-25 moderate, 4/15/13-16 moderate; BDI-II: Baseline-24 moderate, 3/20/13-37 severe, 4/15/13-45 severe. Present Medications: Glyburide 2.5 mg, Ibuprofen 800 mg, Lisinopril 5 mg, Metformin 500 mg, and Paroxetine 20 mg. Mental Status: His mood was slightly dysthymic while his affect was broad and appropriate to content. Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition, chronic. Major depressive disorder, single episode, moderate. Axis II: no diagnosis. Axis III: Injury to neck, R-shoulder, R-wrist, R-ribs, R-leg and low back. Axis IV: Problems related to personal physical injury; occupational, economic, and educational issues. Axis V: GAF-Current: 59; Estimate pre-injury: 80+. Vocational Status/Plan: He remains off work at the present time. He states that he is able to operate a forklift and is interested in returning to another warehouse position commensurate with his physical abilities. Self Report: He has made significant progress in to wearing his back brace and in walking without the cane which he was using as recently as the beginning of his second 10 days in the program. He notes that he now goes out more with his family. He interacts well with other patients in the program and reports feeling happier. Plan: It is recommended that the claimant be approved for participation in the Chronic Pain Management Program in order to increase his physical and functional tolerances and to facilitate a safe and successful return to work.

On April 25, 2013, in a preauthorization request for chronic pain management program it was noted that the chronic pain program had exerted a positive impact on his symptoms, but had not met the targeted reduction of 75% in every active symptom. His previous PDL was listed as Medium, current PDL as Medium (occasional lifting) and Heavy (frequent lifting), required PDL as Very Heavy. Post-Injury ADLs Alterations were documented. It was also noted that had evaluated the claimant and noted he was an appropriate candidate for

progression to a chronic pain program. Components and Goals of Treatment were documented.

On April 30, 2013, performed a UR. Rationale for Denial: He has now completed 160 hours of chronic pain management program and current request is for additional 80 hours. Psychometric testing shows depression increased greatly during chronic pain management program (BDI-2 went from 24 to 46), anxiety also increased (currently BAI=16, was 5 at start of program). FABQ remains elevated and pain level plateaued at 7/10 in last two weeks of chronic pain management program. No longer taking any narcotics. Does not have a job to return to. I do not believe there is sufficient evidence of progress in CPMP or a clear rationale to exceed the ODG standard 160 hours.

May 8, 2013, a reconsideration for request for chronic pain management program stated that in response to the previous denial that work stimulation goals for the next 10 days was included in the request. It was also stated that the claimant made significant progress in not wearing his back brace and in walking without the cane which he was using as recently as the beginning of his second 10 days in the program. It was noted his coping skills did improve, he was sleeping better, and he had made functional improvements.

On May 29, 2013, performed a UR. Rationale for Denial: Patient has made further progress in lifting and other functional measures. Continues in Medium PDC level. He has now been on Paroxetine and takes only Ibuprofen for pain. No significant changes on FABQ, or CSQ since the last evaluation and BDI has worsened. The gains made are minimal compared to the amount of time and intensity of service involved in the last two weeks of the program, so I will have to question requestor about why he thinks another 80 hours is justified. They believe that he is making significant progress, but it has been slowly. He just stopped using his cane in the last 10 days. The request is not justified within ODG guidelines, since this request takes the patient past 160 hours of the chronic pain management program (and he has also had work hardening for this injury). He is taking no pain medication, depression has worsened since the half-way point of the program and he has made very limited gains in the last two weeks. It is unclear why he should continue with this program and why one would expect him to make substantial progress.

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

The previous adverse determinations are upheld. The request for an additional 80 hours of Chronic Pain Program after already receiving 160 hours of Chronic Pain Program is not found to be medically necessary. ODG recommends total treatment duration should generally not exceed 20 full-day (160 hours) sessions and treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Although it was self reported that the claimant has made significant progress in wearing his back brace and in walking without the cane which he was using as recently as the

beginning of his second 10 days in the program, that he now goes out more with his family, that he interacts well with other patients in the program and reports feeling happier, and has made further progress in lifting and functional measures, he has minimal changes in FABQ scores. His BAI and BDI-II scores have also worsened since the beginning of the program which is a concern. I agree with although gains have been made in some areas, they are minimal compared to the amount of time and intensity of service involved in past 160 hours and there is not enough evidence that continuation above the recommended 160 hours would help him to make substantial progress. Therefore, the request for Additional 80 hours of Chronic Pain Program is denied.

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)**