

# AccuReview

An Independent Review Organization

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## Notice of Independent Review Decision

**[Date notice sent to all parties]:** March 3, 2013

**IRO CASE #:**

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

Additional 80 hours of Chronic Pain Management Program

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

This physician is board certified in anesthesiology and pain management with over 37 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:**

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

The claimant is a xx year old female who was injured while performing her customary duties as a xxxxx for a xxxxx on xxxxxxx. She went to open the oven door where she was xxxx and the door stuck and she felt a ripping pain in her shoulder and neck. She is currently employed, yet not working and has fear of losing her job.

10-24-12: Functional Capacity Evaluation dictated by, DC. Claimant job description is Medium Work lift category. Recommendations: As a result of the initial 80 hours of chronic pain management program, the claimant has made objective improvements in her strength and endurance measures noted. She is still not ready to return to work due to her impaired range of motion, swelling, strength and pain symptom status. Return to work at this time would be danger of re-injury and she would not be able to perform her job with safety and efficiency. It is recommended that the claimant would improve her strength and decrease her pain, decrease risk for re-injury, and decrease her impairment if she participated in a two week extension of the chronic pain management program.

12-07-12: Rationale dictated by, DC. A specific individualized care plan addressing current functional tolerance for various tasks in order for the patient to be safely prepared to return to work following the chronic pain management program with the following new methods to achieve goals: 1. Interval exercise routine: utilizing sets of exertion and recovery periods, specifically altering types of exertion activities on a daily and weekly basis. 2. Gradually decrease the length of time for each exercise interval: increased reserve capacity in heart and expanding lung volume. 3. Progressively (repeated changes in the same direction) rather than exercising for long periods to increase intensity levels. 4. Acceleration: adapting faster to demands. 5. Develop home exercise program incorporating above techniques combines with self-treatment options that include self massage and acupressure, breathing exercises for stress reduction and increased circulation to injured areas. The goals listed above cannot be achieved without an extension of the chronic pain management program for an additional and final 10 days of care.

12-07-12: Functional Capacity Evaluation. Clinical Assessment: diagnosis on 820.9 sprain shoulder/arm, 847.0 sprain neck by referring doctor. Compressible areas in this injury include: cervical, right shoulder. Assessment: The claimant

cannot safely perform their job demands based upon this comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: 1. Any referral's that treating doctor feels is necessary to help the claimant's condition. 2. The claimant would benefit from continued care with their treating doctor to address deficits and positive aggravations of the current condition as needed. 3. Recommend continued participation in the multidisciplinary CPMP to address mental and psychological issues that are complicating claimant's progression in their treatment program and ultimately their return to gainful employment.

01-09-13: Reassessment for Chronic Pain Management Program Continuation dictated by, MS, LPC. The claimant performed well in her 20 days of CPMP and overall she appears to be coping better with pain according to the CSQ-R. Her Oswestry disability index has vast improved going from 70% prior to the program to 30% currently. Her overall level of pain seems to be decreasing as well according to the VAS and her anxiety and depression are decreasing as well. Recommend another 10 days to help achieve her goals of treatment. Present medications: Tramadol, Lyrica, Flexeril, Ambien, Atenolol, Protonix. Multiaxial Diagnosis: Axis I: 307.89, Pain Disorder associated with both psychological factors and a general medical condition, chronic, 296.23, major depressive disorder, single episode, severe without psychotic features; Axis II: V71.09, no diagnosis; Axis III: Injury to neck and shoulders – see medical records; Axis IV: primary, occupational, economic, and social; Axis V: Current GAF = 62 Estimated Pre-injury GAF = 85+. Claimant has exhausted conservative treatment yet continues to struggle with pain and functional problems that pose difficulty to her performance of routine demands of living and occupational functioning.

01-18-13: UR performed by, MD. Reason for denial: The request for additional chronic pain management program would not be supported at this time. The guidelines indicate the total treatment duration should not exceed 20 full day sessions or 160 hours. The current recommendation for an extra 80 hours would be in excess of 160 hours. There is no significant documentation of improvement with records provided for review. The claimant reportedly has noted increased frustration, increased anxiety, and increased sleep disorder with the treatment provided thus far. Minimal reports of increased range of motion were documented with the shoulder. Without significant clinical improvement, further chronic pain management program in excess of the 20 day, or 160 hours, recommended by guidelines, would not be supported. The request for additional 80 hours of chronic pain management program is not certified.

01-25-13: Reconsideration: Continuation Chronic Pain Management Program Preauthorization Request dictated by, PsyD, LPC. Claimant previous PDL: Sedentary; Current PDL: Sedentary-light; Required PDL: Medium. Recommend additional 80 hours of CPMP as it is medically necessary to extinguish active symptoms over a long term basis, maximize her functional tolerances, and propel her toward a safe return to work.

02-12-13: UR performed by, PsyD. Reason for denial: Claimant recently completed 160 hours of CPMP and peer review on 12/28/12 concludes that no further functional restoration program is necessary. She takes Tramadol, Lyrica, Flexeril, Ambien, but no narcotics. After speaking with Dr., the claimant's symptoms such as frustration, anxiety, sleep disturbance actually increased with previous CPMP. She remains on many medications. Fear avoidance with work did not change on FABQ. Based on documentation reviewed, there is insufficient justification to exceed the ODG standard of 160 hours of CPMP. Request is denied.

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

The previous adverse determinations are upheld and agreed upon. The claimant has had 20 days, or 160+ hours of a chronic pain management program, with apparent increased apprehension and anxiety. Based on ODG Criteria 12 for the general use of multidisciplinary pain management programs, duration of treatment should generally not exceed 20 full-day (160 hours) sessions without a clear rationale for an extension. This criteria is not met as the claimant continues to utilize many medications including Tramadol, Lyrica, Flexeril, and Ambien, her apprehension and anxiety increased following, and it was documented that fear avoidance with work did not change on FABQ. Therefore, after reviewing the medical records and documentation for this case, the request for Additional 80 hours of Chronic Pain Management Program is not medically necessary and is denied.

Per ODG:

restoration programs)	<p><b>Criteria for the general use of multidisciplinary pain management programs:</b>  <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</p>
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	<p>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 should be performed;</p> <p>(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</p>
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	<p>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). (<a href="#">Sanders, 2005</a>) 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 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. (<a href="#">Keel, 1998</a>) (<a href="#">Kool, 2005</a>) (<a href="#">Buchner, 2006</a>) (<a href="#">Kool, 2007</a>) 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 <a href="#">Chronic pain programs, opioids</a>; <a href="#">Functional restoration programs</a>.</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)**