

Medical Assessments, Inc.

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Notice of Independent Review Decision

November 8, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Units of Chronic Pain Management Program for the Right Knee, 5 Times a Week for 2 Weeks as an Outpatient

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

The Reviewer is Board Certified in the area of Physical Medicine & 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:

09/09/2013: Evaluation
09/18/2013: Behavioral Evaluation
09/30/2013: UR performed
10/01/2013: Request for Reconsideration
10/10/2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx from a slip and fall resulting in a right knee injury.

09/09/2013: Evaluation. Claimant was seen for per post op appointment following surgery on 05/08/13 for her right knee. Claimant stated that at that time she had not had physical therapy in two weeks due to work comp denying it. Claimant was currently doing some home exercises and wearing her knee brace at all times. Medications: Meloxicam 15mg. Impression: Right knee ACL reconstruction. Plan: Knee: the claimant continued to have knee pain and was currently walking with a crutch. Advised that it is important that claimant continue with physical therapy in order for her to improve. Claimant needed to start taking an anti-inflammatory. Continue physical therapy per the ACL protocol. Claimant will wear the ACL brace. Medications prescribed: Celebrex 200mg.

09/18/2013: Evaluation claimant was referred for behavioral evaluation who requested input regarding treatment planning, in particular whether referral for mental health treatment would be appropriate.

Objective Findings: Since the work-related injury, the claimant's psychophysiological condition has been preventing her from acquiring the level of stability needed to adjust to the injury, manage more effective pain and improve her level of functioning. The claimant's psychological symptoms appeared to be marked by the following: Appetite increase, Energy Decrease, Sadness or Down Feelings, Insomnia, Frustration, Inability to get Pleasure out of Life, Increased Sensitivity, Motivation Decrease, Helplessness, Boredom, libido Decrease, Discouragement About the Future, Feelings of Inadequacy, Not Able to Relax, Appetite Decrease, muscle Tension, Difficulties Adjusting to the Injury, Restlessness, Fear of Re-Injury, Concentration Difficulties, Increased Concerns about Physical Health, Increased Pain with Emotional Upset.

Medication Status: Hydrocodone, Celebrex

Psychiatric History: No known family history of psychiatric disorders, alcoholism or suicide. Denies any suicidal or homicidal ideation or attempts in the past. Claimant denies receiving any forms of mental health therapy in an inpatient or outpatient mental health facility.

Psychosocial: Claimant is receiving Worker's Compensation and her financial situation is a major stressor for her. The claimant displays a very good work ethic and vocational motivation, as evidenced by her motivation to return to a good job position, when she is physically and emotionally prepared to handle the responsibilities.

Current Complaints: Claimant reported having difficulty managing her pain and experiences a great deal of interference with activities of daily living due to her pain and difficulties adjusting to her injury. Claimant reported feeling of depression and anxiety, which are secondary to the work related injury. Claimant also experienced stress regarding the treatment process of her injury and would prefer to return to work without experiencing her pain and other physical symptoms. She is feeling more sensitive and becoming emotional since her injury. Claimant had tried to remain as active and involved with her family as possible; however, is having difficulty coping with her pain and adjustment difficulties relating to her injury. She reported that her experience of physical and emotion pain had created problems within her social functioning. Without intervention these maladaptive behaviors and feeling with continue.

The Beck Depression Inventory II scored the claimant a 21, within the moderate range of the assessment. The Beck Anxiety Inventory measures the severity of the anxiety in adults. The claimant scored an 18, within the high range of the assessment. Claimant was given the Opioid Assessment for Pain-Revised. Claimant scored a 7, indicating a low risk for abuse of prescribed narcotic pain medications. Claimant was given the Fear Avoidance Beliefs Questionnaire. Work Score score was 38 out of 42 and Activity Scale was 12 out of 24.

Mental Status Exam: Claimant was on time for this appointment. She appeared neat and clean, and seemed her stated age. She seemed oriented in all spheres. Thought process was logical and goal-directive and her answers were thoughtful and reflective. Mood seemed depressed at times, and her affect was appropriate to content. The claimant displayed good eye contact at times and seemed to have good insight and judgment.

Clinical Rationale for Requested Procedure(s): Being the claimant had not been able to become stabilized enough to enhance coping mechanisms to more effectively manage pain and achieve success in rehabilitation, it is being requested that she participate in 10 sessions of a behavioral multidisciplinary chronic pain management program. Without this type of intensive intervention her maladaptive beliefs and thoughts are likely to continue in a downward spiral as the chronic pain continues to affect the claimant's quality of life. It is crucial that this claimant receive other necessary components, which are not provided in individual therapy, to help obtain the tools needed to succeed and increase overall level of functioning.

Treatment Plan Goals: Claimant's self-reported tendency toward experiencing feelings of depression, anxiety, and somatization this, impair future adjustment to employment. Individuals with this complex interplay of psychological and physiological symptoms tend to respond more favorably and rapidly to a multidisciplinary Chronic Pain Management Program.

Summary: The pain resulting from the claimant's injury has severely impacted normal functioning physically and interpersonally. Claimant reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain has reported high stress resulting in all major life areas. The claimant will benefit from a course in pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. Claimant should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring.

09/30/2013: UR performed. Rationale for Denial: When noting the date of injury, the lack of objectification of the pathology within the knee that is causative of such a program, and that there is no discussion as to any additional surgery, there is insufficient clinical data presented to suggest that this program is warranted at this time. As such, this request is not certified.

10/01/2013: UR performed. Rationale for Denial: This is a morbidly obese individual who underwent an anterior cruciate ligament repair and had not initiated postoperative rehabilitation protocols. To declare this a chronic pain situation less than 6 weeks after surgery is premature at best. While it's agreed that a

rehabilitative physical therapy protocol for the injury is clinically indicated, there clearly is no documentation that this is a chronic pain situation. Therefore, there is insufficient clinical data to suggest that a multidisciplinary chronic pain program is needed less than 6 weeks after the date of surgery. Furthermore, it is unclear if this is a program that has any successful outcomes as required in the first sentence of the official disability criteria.

10/01/2013: Request for Reconsideration. Claimant has exhausted all lower levels of care and is pending no additional procedures. Official Disability Guidelines from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment. The results of an outcome study performed by Proctor, Mayer, Theodore, and Gatchel demonstrated that patients who do not complete a chronic pain program are 7 times more likely to have post-rehabilitation surgery in the same area and nearly 7 times more likely to have more than 30 visits to a new health provider in persistent healthcare-seeking efforts. The study also demonstrated that patients who do not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and 7 times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program is the recommended course of treatment to help an injured worker return to work and is considered the treatment of choice by the national standards cited above. Ms. meets the criteria for the general use of multidisciplinary pain management program, according to the Official Disability Guidelines, chronic pain chapter.

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

Denial of 80 hours of chronic pain management for right knee is upheld/agreed upon since there is significant lack of clinical information. In accordance to ODG pain chapter there is no documentation of reconditioned state (1,b) nor of functional deficit (1, d) since there is no submitted functional testing and no comparison to job demands. There is question of previous treatments and progress. There is no indication of the number of basic Physical Therapy visits, compliance with attendance and home exercises or any improvements in range of motion or strength (2). There is no physical exam of the involved body part - the right knee -No range of motion, strength, laxity, provocative testing, tenderness, gait, brace wear, assistive device use (3,a). There are no specifics regarding medications particularly opioid (Hydrocodone) use(number a day), abuse, misuse, adverse side effects, dependence (3,b and 5). There is no specific treatment plan - particularly goals regarding function and return to work (with no mention of type of work/ job to return to). Nor plan regarding medication management - weaning off opioid Hydrocodone. Nor consideration of evaluation or need for psychotropic medication for depression or anxiety (6). Therefore, there is insufficient information to support a change in determination and the request for 80 Units of Chronic Pain Management Program for the Right Knee, 5 Times a Week for 2 Weeks as an Outpatient is denied.

ODG Guidelines

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

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)**