

Health Decisions, Inc.

506 Winchester Dr.

Celina, TX 75009

P 972-800-0641

F 888-349-9735

Notice of Independent Review Decision

[Date notice sent to all parties]: September 18, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 additional hours of CPMP

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:

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:

05-13-13: Physical Performance Evaluation (Poor copy)

07-25-13: Physical Performance Evaluation (Poor copy)

08-01-13: Reassessment for Chronic Pain Management Program Continuation

08-02-13: Request for 80 Final Hours of A Chronic Pain Management Program

08-07-13: UR performed

08-15-13: Reconsideration: Continuation Chronic Pain Management Program
Preauthorization Request

08-21-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He fell sideways landing on his shoulder. Treatment included physical therapy, injections and two surgical procedures followed by post-surgical physical therapy. Treatment also included 4 sessions of individual psychotherapy. He also failed a 10 day trial of work hardening. He underwent 80 hours of a Chronic Pain Management Program, but

continues to report marked pain and unresolved functional problems that are associated with reliance on significant others to complete ADLs.

May 13, 2013, The claimant underwent a Physical Performance Evaluation and was found to be in the Light PDL category.

July 25, 2013, The claimant underwent a Physical Performance Evaluation and was found to be in the Light PDL category.

August 1, 2013, performed a Reassessment for Chronic Pain Management Program Continuation. Assessments utilized and results of those assessments are as follows: FABQ-Work: Baseline: 36, 10 days: 36, 20 days: 39, Goal: 7; FABQ-PA: Baseline: 18, 10 days: 12, 20 days: 12, Goal: 4; Oswestry Disability Index: Baseline: 32%, 10 days: 28%, 20 days: 44%, Goal: 6.4%; BAI: Baseline: 8, 10 days: 5, 20 days: 6, Goal: 1.2; BDI-II: Baseline: 12, 10 days: 8, 20 days: 17, Goal: 2; VAS PAIN: Baseline: 6, 10 days: 7, 20 days: 7, Goal: 1. Present Medication Usage: Hydrocodone 7.5-325 mg and Meloxicam 7.5mg. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic. Axis II: no diagnosis. Axis III: Injury to shoulder. Axis IV: Primary support group, Economic and Occupation problems. Axis V: GAF-Current 65; Estimated pre-injury 85+. Plan: was injured while performing his customary duties. He is still employed. He would like to go back to the same job and position but he is not sure whether or not he will be able to go back to work. If he cannot return to his same job position, he would like to take another position within the same company. Treatment Plan: Continue 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. In accordance with ODG recommendations, a specific individualized care plan addressing current functional tolerance for various tasks, as well as the requisite tolerance for those tasks was indicated.

August 2, 2013, in a request for 80 Final Hours of CPMP it was noted that according to FCEs, the claimant was previously at Light PDL, currently at Light PDL and his job requires a PDL of Heavy. It was also indicated that he began with walking only 30 minutes, improved to 40 minutes, now at 50 minutes. Cardio exercise began at 15 min, improved to 25 min, and now at 30 min. Resistance training began at 15 min, improved to 20 min and now at 25 min. It was also noted he still needs help with opening jars/cans, vacuum/sweeping/mopping, doing laundry, and doing yard work. Goals for treatment were provided.

August 7, 2013, performed a UR. Rationale for Denial: There does not appear to have been much improvement achieved from the previously completed 80 hours of a chronic pain management program as there was mention on 8/02/13 of the patient continuing to report marked pain and unresolved functional problems that were associated with reliance on others to complete activities of daily living (ADLs) and unemployment as well as mention of the patient still on multiple medications including Hydrocodone and Meloxicam. There was also mention of the patient's pain, frustration, anxiety, and depression remaining the same after

80 hours of the program. Therefore, the additional 80 hours of a chronic pain management program is not medically reasonable or necessary.

August 15, 2013, in a request for reconsideration, it was indicated that the claimant did have a 9% increase in static pull strength and 25% in pallet to table lift occ, pallet to table lift freq, table to mid chest lift occ, table to mid chest lift freq, and mid-chest to overhead lift occ. It was also noted that he did report similar psychological symptoms following completion of the first 80 hours, but he also had an increase in psycho social stressors. It was reported that his injury related circumstances were starting to cause instability in his relationship with his significant other and that he had been feeling more and more anxious about being able to go back to work and contribute to some kind of gainful employment. He was also reportedly having difficulty trying to find acceptance that he may not be rehabilitated back to 100%. Despite the increase in stressors, it was reported that he was able to maintain his level of overall stress by implementing many of the coping strategies and techniques he extrapolated from his participation in the chronic pain management program.

August 21, 2013, performed a UR. Rationale for Denial: In this case, the claimant presents with minimal to no improvement in psychological functioning, unclear progress in medication weaning and very minimal improvement in strength. The case was discussed with the provider, and it should be known that the opinions set forth by this provider are much respected. However, the claimant has reportedly received 160 hours of a comprehensive pain management program to date. This amount should be sufficient to meet the desired goals, per criteria set forth by Official Disability Guidelines. Without clear objective and progress towards stated program goals and the maximal amount of treatment supported by ODG completed, medical necessity of ongoing program participation is not supported.

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

The previous denials of 80 hours of CPMP are upheld/agreed upon since per ODG criteria # 10, there has been no significant subjective or objective gains with continued LIGHT functional level and actually an increase in pain and disability parameters and very little change in psychometric parameters and clinically no information regarding change in medication use and no specific vocational plan presented despite off from very heavy job of injury.

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)**