

Health Decisions, Inc.

4517 Coconino Court
Fort Worth, TX 76137
P 972-800-0641
F 888-349-9735

Notice of Independent Review Decision

December 1, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program – 80 hours/units Outpatient

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

Board Certified Chiropractor with over 18 years' 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female that slipped on xx/xx/xx and injured her lower back, right hand, wrist and shoulder. She has had 80 hours of chronic pain management, pain medications and physical therapy without relief.

07-11-14: Functional Capacity Evaluation. The claimant has been diagnosed with disorders of the sacrum and sprain lumbar region. She states she has back pain that radiates to her calf that she rates 3/10. ROS: Lumbal (L4) saphenous L WNL R hypoesthesia; Lumbal (L5) Common peroneal L WNL R hypoesthesia; Sacral (S1) superficial peroneal L WNL R hypoesthesia. ROM: Flexion avg 80, extension avg 30, lateral flexion L avg 25 R 25, SLR L 65 R 65. Functional specific testing: Balance L pain 3/10 R pain 4/10, crawl 4/10, crouch 4/10, kneel 3/10, reach overhead and shoulder 3/10, sit 4/10, squat 4/10, stand 4/10, stoop 4/10, walk 4/10. Findings: Trigger points in the area of injury, muscle restrictions in the area of injury, decreased ROM. Assessments: Improvement in ROM, improved static strength. Recommendations: A psychological eval, cont care with treating doctor, physical therapy and home exercise program.

10-01-14: Physical Performance Evaluation. The claimant rates radiating back pain 4/10. ROM: Extension L 30, lateral flexion L 30, SLR L 55. Findings: Pain with walking, sitting, stooping, squatting and crouching. Assessments: Improvements in static strength, dynamic lifting and Oswestry Low Back Disability Index. Recommendations: Continue chronic pain management program.

10-08-14: Reassessment for Chronic Pain Management Program Continuation. The claimant presently uses cyclobenzaprine, Ibuprofen and Tramadol. Mental status evaluation: Mood was euthymic and affect was broad (normal). Diagnosis: Symptom disorder with predominant pain, persistent, moderate. Treatment recommendations/Plan: Continue participation in the chronic pain management program in order to further increase her physical and functional tolerances, maintain the progress she has made and to facilitate a safe and successful return to work.

10-13-14: URA. Rationale: This patient was injured on the job on xx/xx/xx and finished physical therapy and recommended to work hardening. There is insufficient progress with the first 80 hours of the program. ODG notes, "Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains." There is no medication goals/progress noted. She failed to improve her activity levels at home. Fear and avoidance scales increased as did pain scores. Her perceived disability scores increased as well. She does not qualify for additional chronic pain management based on this negative progress and lack of functional response. As such the request for an additional 80 hours of Chronic Pain Management Program is not certified.

10-24-14: Reconsideration: Continuation Chronic Pain Management Program. Improvements per patient: getting stronger, able to relax, sleep hygiene and has positive outlook for the future. Reduction in irritability, muscle tension, sleep problems, ability to ignore pain, utilizing coping skills and forgetfulness.

10-31-14: URA. Rationale: ODG states, "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)." In peer review conversation with the treating provider, he indicated that the patient did successfully complete 80 hours of chronic pain management program and had some objective evidence of improvement. His goal is to help her reduce pain, reduce narcotic medication use, and return to her previous job duties. He reviewed the clinical notes with me. The treating provider has requested an additional 80 hours to further promote her pain control and improve her possibility of returning to work. ODG guidelines below will support up to 160 hours of a chronic pain measurement program if specific criteria are met. Therefore, the request for an Appeal Additional Chronic Pain Management Program x 80 hrs for Lumbar Spine is medically necessary.

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

The claimant is a female that was injured in a work injury on xx/xx/xx. On xx/xx/xx, the claimant slipped and injured her lower back, right hand, wrist, and shoulder. The claimant has completed 80 hours of a chronic pain management program and physical therapy with minimal results. As noted in the records on 7/11/2014, a FCE performed showed that the claimant had lower back pain radiating to the calf, with the pain rated a 3/10 (10 being the worst pain experienced). Right L4, L5 hypoesthesia, and straight leg raise positive bilaterally at 65 degrees. ROM of the lumbar spine shows measured at flexion 80 degrees, extension 30 degrees and LF bilaterally at 25 degrees. Functions such as balancing, crawling, crouching, kneeling, stooping, sitting, standing, squatting, walking, and reaching overhead was noted as painful. On 10/1/2014, a PPE was performed and revealed an increase in pain to 4 out of 10. ROM increased by 5 degrees in LLF, but SLR was positive at 55 degrees, which was less than on the FCE dated 7/11/2014. noted with walking, sitting, stooping, squatting, and crouching. At this time, the request for furthering the CPM was requested. On 10/13/2014, a URA explained that the request for further CPM was not certified because of lack of positive progress and functional improvement. On 10/31/2014, an URA was performed was performed and discussed and the request for additional 80 hours of CPM was approved for the lumbar spine was granted. After reviewing the records that have been submitted and per the ODG guidelines which specifically states that "treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains." In comparing the FCE dated 7/11/2014, and the PPE dated 10/01/2014, the only positive improvement was 5 degrees in LLF, and no significant objective or functional gains were noted, therefore the approval of additional Chronic Pain Management program x 80 hours for the Lumbar spine is not medically necessary.

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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (Sanders, 2005) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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)**