

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

January 21, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 80 hours

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

Chiropractor

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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:

- 11-7-13 MA, initial interview

- 11-7-13 Functional Capacity Evaluation
- Request for chronic pain management program on 11-12-13
- 11-15-13 UR denial
- Utilization Review Request form on 12-12-13
- 12-12-13, Request for Reconsideration
- 12-19-13, UR Reconsideration upheld
- Request for a review by an IRO on 1-6-14
- 1-7-14 IRO Request Details
- IRO request for medical documentation on 1-9-14

PATIENT CLINICAL HISTORY [SUMMARY]:

11-7-13, the claimant sustained a work related injury on xx/xx/xx. The claimant reports that he felt immediately sharp pain in his lower back, causing him to fall on top of his knees to the ground. He has received various diagnostic tests and participated in several levels of treatment for his work related injury including: passive and physical therapy sessions, lumbar fusion procedure in 2001, lumbar fusion revision procedure in 2003, lumbar fusion revision procedure due to staph infection in 2003, around six lumbar epidural steroid injections, post operative rehabilitation services, aquatic therapy, and medication management. Findings: Lumbar Disc Derangement. Lumbar Radiculitis. His diagnosis and chronic pain are causally related to his work injury. Significant functional limitations and de-conditioning status that require medical, rehabilitative, psychological, social, and vocational changes. Pain Disorder with both Psychological Factors and a General Medical Condition. Life problems connected to work injury and pain status. GAF 60, BDI-II 35, BAI 25. Motivation and mental capability to make added progress. Plan: The claimant meets the criteria for the general use of multidisciplinary pain management program, according to ODG, chronic pain chapter.

11-7-13 FCE shows the claimant is functioning at a Sedentary PDL.

Request for chronic pain management program on 11-12-13.

11-15-13 notes the request for authorization of Chronic Pain management program x 80 hours was received by UR Agent Physician Advisor and it was determined that it does not meet medical necessity guidelines. As the requesting provider, you were

provided with a reasonable opportunity to speak with the Physician Advisor regarding your request prior to the determination being made. UR performed, notes that the claimant has not worked since the injury on xx/xx/xx. The claimant is status post 4 lumbar surgeries. There is no documentation in the archives or submitted documentation of any supervised treatment in the last several years. There are no red-flags or compelling rationale why a chronic pain management program would be medically necessary at this time. stated during our peer to peer that his intent was to 'wean him off medication', however there is no discussion of medication abuse or complications. There is no evidence of previous attempts to wean the claimant off medication. Given the submitted documentation, the request does not appear to be medically necessary.

Utilization review request form on 12-12-13.

12-12-13, Request for Reconsideration notes the claimant meets the criteria for the general use of multidisciplinary pain management program, according to ODG, chronic pain chapter. He noted that Mr. 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.

12-19-13, notes an appeal of the UR denial determination issued on 11-15-13, for the chronic pain management program x 80 hours was received on 12-19-13. It was determined that it does not meet medical necessity guidelines. UR performed, noted that Employee is post soft tissue injury low back and although he has undergone multiple back surgeries, his last surgery appears to have been over 10 years ago in 2003 or 2004 when he had a lumbar fusion revision procedure due to a staph infection and post-operative rehab has been completed. Other than on-going medication management, employee has not required or undergone any other procedures or treatment for any documented flare-ups, exacerbations or aggravations of his work injury over the past several years. Employee has not worked and his continuous disability is a negative predictor of success; and the fact that the employee tested at a sedentary PDL on the FCE dated 11/7/13 also serves as a negative predictor in that dynamic lift tests were suspended due to increased low back pain, muscular fatigue and the employee reaching his maximum lift ability. It is highly unlikely that the employee would only test at a sedentary level after having been through post-operative rehab and instructed on a HEP and being

highly motivated, as stated in the submitted records, participating in a daily home exercise program over the last 10 years. It is unlikely that the employee will return to a heavy PDL and if the intent of the program is to wean the employee off pain medications, then a multidisciplinary RTW program is not required to accomplish this goal. The submitted information on appeal does not support overturning the previous denial decision; and in his opinion, the request does not comply with ODG. It is his opinion that the documentation does not support that the appeal request for CPMP x 80 hours is reasonable and/or medically necessary.

Request for a review by an IRO on 1-6-14.

1-7-14 IRO Request Details, the request has been successfully submitted.

IRO request for medical documentation on 1-9-14.

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

Review of the submitted documentation shows that the claimant is has undergone multiple surgical procedures and other interventions. However, records do not indicate that the claimant has had any supportive or interventional treatment in the last several years. Most recently, he tested at severe levels of both depression and anxiety. Pain levels are moderate and testing shows a sedentary level of physical capacity. Documents indicate that the claimant is taking narcotics and wishes to eliminate these medications. Guidelines for multidisciplinary pain management programs expect that all lower levels of care be exhausted prior to entry into these programs. In this case, the claimant has not addressed dependence on narcotics or the severe psychological issues in any therapeutic setting to date. Additionally, the claimant's physical limitations do not appear to have been moderated by supervised therapy or any attempt at home exercise or self-directed care. Lower levels of care have not been exhausted. Negative predictors, as described in clinical guidelines, should be addressed before consideration of entry into CPM programs. In this case, the claimant's lengthy period of disability and high levels of depression and anxiety have not been clearly addressed with regard to an expectation of a successful outcome. In addition, no attempt at return-to-work, whether a failure or success, over the last half-dozen years has been noted. Likewise, no description of a failed attempt to decrease medications is described in the documentation submitted. Given the above, in accordance with evidence-based guidelines, the medical necessity of the request for a Chronic Pain Management Program x 80 hours is not reasonable or medically necessary.

Per ODG 2013 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, outpatient 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.

IRO REVIEWER REPORT - WC

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)