

# AccuReview

An Independent Review Organization  
569 TM West Parkway  
West, TX 76691  
Phone (254) 640-1738  
Fax (888) 492-8305

## Notice of Independent Review Decision

**[Date notice sent to all parties]:** February 17, 2014

### **IRO CASE #:**

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

Chronic Pain Management Program – final 80 hours/units - outpatient

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

This physician is Board Certified in Anesthesiology with over 12 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:**

04-30-12: Physical Performance Evaluation dictated by DC

11-18-13: Preauthorization

12-13-13: Physical Performance Evaluation dictated by DC

12-17-13: Reassessment for Chronic Pain Management Program Continuation Following RTW & 2 Additional Surgeries dictated by LPC

01-02-14: Continuation: Chronic Pain Management Program Preauthorization Request

01-16-14: UR performed by DO

01-27-14: Reconsideration: Continuation Chronic Pain Management Program  
Preauthorization Request dictated by PsyD  
02-03-14: UR performed by MD

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is female who sustained a work related injury on xx/xx/xx when she felt a pop in her right knee. The current diagnoses include right knee pain and s/p right knee surgeries.

04-30-12: Physical Performance Evaluation dictated by DC. Claimant stated she has taken a leave from work since DOI up to date of this exam. Job Description: Lift Category: Light Work. Current Medications: Hydrocodone Bitartrate and Acetaminophen, Lisinopril, Welbutrin. Assessments: The claimant is able to return to work with restrictions. Recommendations: Any referrals the treating physician feels is necessary to help the claimant's condition; continued care with treating physician to address residual deficits and possible aggravation of their current condition on an as needed basis; capable of returning to gainful employment with restrictions; claimant is capable of performing their job duties (with restrictions) until they demonstrate objective improvements and the ability to perform safety and efficiently at their place of employment.

11-18-13: Preauthorization. Services Requested: Functional restoration/Return to Work Program. Special Comments: program care.

12-13-13: Physical Performance Evaluation dictated by DC. Assessment: The claimant cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: Any referrals the treating doctor feels necessary that will help the claimant's condition; continued care with treating doctor to address residual deficits and possible aggravation of their current condition on a as needed basis, based on the findings, the claimant may benefit from a referral to functional restoration program; claimant is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

12-17-13: Reassessment for Chronic Pain Management Program Continuation Following RTW & 2 Additional Surgeries dictated by LPC. Multiaxial Diagnosis: Axis I: 307.89, Pain Disorder associated with both psychological factors and a medical condition, chronic. 296.21, Major Depressive Disorder, Single Episode, Mild; Axis II: V71.09, no diagnosis; Axis III: Injury to right knee—See medical records; Axis IV: Primary Support Group, Housing, Economic, and Occupational Problems. Axis V: GAF=65 (current), Estimated pre-injury GAF+80+. Vocational Status/Plan: The claimant was injured while performing her customary duties as a manufacturing specialist for TI. She reported that she is fearful of whether or not she will be able to physically tolerate the walking and standing required during the shifts. She did return to work for 8 months in a modified capacity before she was taken off work again for additional surgery. Treatment Recommendation/Plan:

We concur with Dr. recommendation that the claimant participate in a final 10 days of CPMP as she 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. The claimant is a highly motivated and compliant person who has made gains with previous treatment. It is logical, appropriate, and medically necessary for the claimant to get the extended physical rehabilitation as well as multidisciplinary treatment afforded only in progress care. Thus, it is recommended that the claimant be approved for 10 final days in the CPMP in order to increase her physical and functional tolerances while decreasing her fear avoidance behaviors so as to facilitate a safe and successful return to work and medical case closure.

01-02-14: Continuation: Chronic Pain Management Program Preauthorization Request. Previous PDL: Light-Medium; Current PDL: Sedentary; Required PDL: Light.

01-16-14: UR performed by DO. Reason for denial: She had 10 days of CPMP in 2011 and is now finishing 20 days of CPMP which is normal length of said program under ODG. Unable to find any reason for further inclusion in additional CPMP under ODG. Unable to certify as such. Documents submitted with request.

01-27-14: Reconsideration: Continuation Chronic Pain Management Program Preauthorization Request dictated by PsyD. Current PDL: Sedentary, Required PDL: Light.

02-03-14: UR performed by MD. Reason for denial: Per records provided, claimant also has significant amount of depression stress and anxiety. This is one of the negative predictors of efficacy of treatment with the program as well as a negative predictor for completion of the program for this claimant. The claimant has increased duration of pre-referral disability time. There is conflicting evidence that chronic pain programs would provide return-to-work in this kind of claimant. With this it is deemed the clinical information submitted for this review does not establish the medical necessity of chronic pain management program.

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

Previous adverse determinations are agreed upon and upheld. Based on records provided, the claimant has a diagnosis of major depressive disorder in addition to stress and anxiety. These factors are a negative predictor of efficacy of treatment as well as a negative predictor of completion of the program. There is conflicting evidence that chronic pain programs would provide return-to-work in this kind of claimant. Therefore, after reviewing the medical records and documentation provided, the request for Chronic Pain Management Program – final 80 hours/units – outpatient is non-certified.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<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 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: (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.</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</p>
--	--

	<p>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 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). (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).</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)</p>
--	---

	<p>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>
--	---

**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)**