

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

December 24, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain management 5xWKx2wks (80hrs) Lumbar/Right Foot CPT Code 97799

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

American Board of Physical Medicine and Rehabilitation
Subcertification in Pain Medicine

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:

- 7-24-13, office visit
- Behavioral medicine assessment on 8-2-13
- 8-28-13 Physical Performance Evaluation

- Individual psychological therapy evaluation on 9-3-13
- Behavioral health treatment pre-authorization request on 9-17-13
- Chronic pain management interdisciplinary plan and goals of treatment on 10-7-13
- Psychological evaluation on 10-7-13
- Chronic pain management program evaluation on 10-7-13
- 10-8-13, office visit
- Psychological testing pre-authorization request on 10-9-13
- Chronic pain management program pre-authorization request on 10-22-13
- Request for 80 hours of a chronic pain management program on 10-22-13
- 10-25-13, notification of adverse determination
- Reconsideration for chronic pain management program on 11-7-13
- 12-2-13, notification of reconsideration determination
- Request for a review by an IRO on 12-5-13
- Notice of Assignment to IRO on 12-10-13
- 12-10-13 Department of Insurance, IRO request details
- Notice to Claims Eval of case assignment on 12-10-13
- Notice to Utilization Review Agent of assignment to IRO on 12-11-13

PATIENT CLINICAL HISTORY [SUMMARY]:

7-24-13, the claimant states there has been a slight improvement in his low back pain. He also states he is experiencing a slight decrease of pain and discomfort of his right ankle. Exam shows a medium degree of pain at L1-5 and the ilium on the left, a strong pain level at L1-5 and the ilium on the right. Moderate tension of the lumbar paraspinal muscles and gluteal muscles on the left, spasm of the lumbar paraspinal muscles and gluteal muscles on the right. Moderate muscular hypertronicity of the right ankle. There is a moderate tenderness level and moderate swelling of the right ankle. Moderate edema at the right ankle. Diagnosis: Displacement of lumbar intervertebral disc without myelopathy. Enthesopathy of ankle and tarsus. Thoracic radiculitis/root compression. Sprain/strain, lumbosacral region. Unspecified site of ankle sprain. Plan: Order soft bilateral longitudinal arch supports. Will continue to monitor progress.

Behavioral medicine assessment on 8-2-13.

8-28-13 PPE shows the claimant is functioning at a Light PDL.

Individual psychological therapy evaluation on 9-3-13.

Behavioral health treatment pre-authorization request on 9-17-13.

Chronic pain management interdisciplinary plan and goals of treatment on 10-7-13.

Psychological evaluation on 10-7-13.

Chronic pain management program evaluation on 10-7-13.

10-8-13, the claimant has a chief complaint of chronic pain management program. Hand written illegible notes. Diagnosis: Lumbosacral syndrome. Lumbar radiculitis. Lumbar sp/st. Ankle sp/st. Plan: Recommended chronic pain management program.

Psychological testing pre-authorization request on 10-9-13.

Chronic pain management program pre-authorization request on 10-22-13.

Request for 80 hours of a chronic pain management program on 10-22-13.

10-25-13, notes the service requested is Chronic Pain Management for the lumbar/right foot. The claimant is a male who reported a work-related injury as a result of strain to his lumbar spine on xx/xx/xx. Status post lumbar fusion on 12/18/12. He has exhausted conservative care he remains unable to return to work. Question the medical necessity of Chronic Pain Management 5xWk x 2Wks (80 hrs.) Lumbar/Right Foot. Diagnosis: Lumbar strain DOI: xx/xx/xx. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The claimant has already completed a work hardening program. He only had a 5 lbs lifting improvement at the end of work hardening program. Psychological scores were slightly worse at the end of this program.

Reconsideration for chronic pain management program on 11-7-13.

12-2-13, notes after careful review of all available information, the Licensed Specialty Advisor has determined that the proposed treatment does not meet medically necessity guidelines. Requested service description: Appeal Chronic Pain Management 5 x week x 2 weeks (80 hours) for lumbar/right foot. The requesting provider stated that the patient continues to demonstrate functional deficits, marked pain and sleep disturbance that are impacting his ability to safely return to work. He requires a more intensive, interdisciplinary pain rehabilitation program in order to resolve active symptoms on a long term basis, dismantle his disabled self-perception, increase his functional tolerances and propel him toward a safe return to work. The provider stated that the patient has exhausted all of the levels of care. He is not a candidate for any injections or further surgery. The patient has failed a trial of work hardening in the past. The pain management program would focus on the patient's behavior including anxiety and fear of avoidance. The psychological component would include biofeedback which is not typically included in the work hardening program. However, he stated that the physical component of both programs is similar and given that the patient feeling a trial of work hardening and was not able to achieve much improvement in the physical level, it seems unlikely that the physical component of the pain management program would be beneficial.

Hence, the necessity of the request is not established. Based on these grounds, the medical necessity of the request is not established in agreement with the previous determination.

Request for a review by an IRO on 12-5-13.

Notice of Assignment to IRO on 12-10-13.

12-10-13 Department of Insurance notes the request has been successfully submitted.

Notice to Claims Eval of case assignment on 12-10-13.

Notice to Utilization Review Agent of assignment to IRO on 12-11-13.

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

Medical records reflect this claimant is status post ALIF at L4-L5 and L5-S1 on 12-18-12. He underwent postop physical therapy and 10 sessions of a work hardening program and four psychotherapy sessions. He is presently not taking any medications other than Tylenol prn. The claimant has already participated in a work hardening program with little to no improvement. There is no indication as to the outcomes for the necessity of use clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. Therefore, the request for Chronic Pain Management 5xWKx2wks (80hrs) Lumbar/Right Foot CPT Code 97799 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, 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.

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)**