

Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

February 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Hours/Units Chronic Pain Management Program

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

The Reviewer is a Licensed Psychologist with over 25 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:

09/06/2013: Health and Behavioral Reassessment
09/06/2013: Functional Capacity Evaluation
10/28/2013: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment
10/29/2013: Psychological Testing and Assessment Report
10/29/2013: Assessment/Evaluation for Chronic Pain Management Program
10/30/2013: Request for 80 hours of a Chronic Pain Management Program
11/04/2013: UR performed
11/05/2013: Appeal Letter
12/05/2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a female who sustained injury to the cervical spine and left shoulder on xx/xx/xx. She fell. She reported landing on her feet but had an immediate headache that lasted throughout the week. She stated that she went to the hospital the following day, at which time they completed an x-ray and CAT scan. She reported that the hospital diagnosed her as having a concussion and she was given prescriptions for pain medications. She is reported to having undergone physical therapy, four steroid injections, three MRI's, three x-rays, one CT scan, and three rhizotomy's. In May 2013 she underwent a fusion. She noticed improvement following the surgery but still suffered from functional limitations and pain. She also underwent a Work Hardening Program and 4 sessions of individual therapy.

09/06/2013: Health and Behavioral Reassessment. Claimant was referred for a health and behavioral reassessment at the directive of her treating doctor. to assess her emotional status and to determine her suitability for some level of behavioral medicine treatment and/or a return to work program. **Present Medications:** Celebrex and Cyclobenzaprine. **Description of pain:** the claimant self-rates on a scale of 1-10 with the worse as a 6, pain level with medications: 4, pain level without medications: 10. Pain level worst: 10 and average daily pain as a 5/10. The claimant describes the pain as a dull, aching, tight, heavy, sore, and tender pain in her neck and left shoulder. When asked to quantify the level of interference her pain has on her recreational, social and familial activities, she rates these all as 5/10; for pain interference with normal activities as 5/10; and change in ability to work, 5/10. Per report the claimant is off work. **Lifestyle Changes Related to the Injury:** Functionally, claimant notes the following difficulties since her injury: self-grooming, household chores, yard work, exercise/playing sports, driving for more than 30 minutes to an hour, sitting for more than 30 minutes, standing for more than 30 minutes, walking, overhead reaching, bending, squatting, crawling, climbing stairs, and lifting/carrying more than 10lbs. max. She rates her level of functioning before the injury at 98% and her current level of functioning at 70%. **Interpersonally:** Claimant notes the following changes in her relationships: more conflict with family, less participation in social outings, and feeling abandoned by co-workers. **Intrapersonally:** she notes the following changes in her self-perception: feeling more sensitive to criticism and feeling helpless at times. She endorsed sleep maintenance insomnia with 2 awakenings per night and early awakening. Her appetite is "up and down" and she has noticed a 6lb increase in her weight due to loss of function. She drinks about one to two beers per day which is somewhat more than she used to drink. **Results of the Beck Depression Inventory-II and the Beck Anxiety Inventory reveal the following.** The claimant's score on the BAI was 12, reflecting mild anxiety. Her responses on the Fear Avoidance Beliefs Questionnaire showed significant fear avoidance of work as well as significant fear avoidance of physical activity in general. After evaluation all these components this clinician found the patient endorses fear avoidance of both physical activities in general, as well as of a work. Additionally, claimant endorsed these 8 out of 9 DSM-IV-TR symptoms for Major Depressive Episode as present for most of the day, nearly every day, for greater than 2 consecutive weeks. **MultiAxial Diagnosis:** Axis 1: Major Depressive Disorder, single episode,

moderate. Pain Disorder associated with both psychological factors and a medical condition. Axis II: No diagnosis. Axis III: Injury to cervical spine left shoulder. Axis IV: Primary support group Social Environment, Economic Problems, and Occupational Problems. Axis V: GAF = 57 (current Estimated Pre-Injury GAF = 75+). **Plan:** Treatment Goals and Objectives were presented. It was recommended the claimant participate in a four sessions of individual psychotherapy intervention to assist her in developing tools and skills for the management of her injury-related disturbances in mood and sleep.

09/06/2013: Functional Capacity Evaluation. **Effort Level:** the claimant was found to provide consistent effort in all areas of the FCE. The claimant's occupation requires a Medium-Heavy functioning level. Based on the FCE, the claimant is functioning at a sedentary level with deficiencies remaining. Claimant has had surgery performed on the R-Elbow with good reported success per claimant's views in relieving pain symptoms, but remains very weak. Claimant present today with a current pain rating of 6/10 on the VAS. Claimant reports she notices that her R-Elbow and C-Spine strength is still weaker than it needs to be, but also knows it is moving much better. She has increased pain after prolonged time on her feet and walking for an extended period of time, and with any type of squatting, stooping, twisting or any weight-bearing movement from an L-Spine issue which restricts her R-Elbow ROM is WNL's. Computerized isometric muscle testing shows mildly increased strength of the bilaterally with her dominant R-Hand presenting stronger than the L-Hand. Claimant is unable to tolerate her work requirements of frequent forward and overhead reaching, bending, squatting and kneeling without increased pain, because any weight-bearing activities elevate her pain levels. Claimant demonstrated difficulty with cardiovascular testing due to increased pain levels to the L-Spine, C-Spine, and pain becoming a limiting factor. Claimant was unable to perform the Modified Naughton Treadmill Test. Claimant did not perform dynamic lifting test as she was not able to squat normally without changing her biomechanics straight from the start. Claimant was unable to work at her pre-injury PDL. Based on today's testing, the claimant was able to demonstrate improvement within her injured areas; she is currently de-conditioned overall and has not made sufficient progress to continue with her work hardening program. Claimant would benefit from by progressing to a more in-depth Chronic Pain Management Program to provide the claimant with the opportunity to improve her physical strength conditioning, develop coping skills, receive safety and wellness education, and improve her overall functional abilities so that she is able to perform at a Physical Demand level sufficient for safe return to work.

10/28/2013: Chronic Pain Management Interdisciplinary Plan & Goals of Treatment. **Psychological Goals- Short Term Behavioral Goals:** Reduce pain from range of 3 currently to less than 2 at discharge by teaching the claimant various pain coping techniques and increasing independent practice of such strategies. Reduce number of pain exacerbations from 7 week currently to less than 3/week. Decrease impact of pain flare-ups and injury-related anxiety through the use of strategies such as relaxation techniques, guided imagery, and/or abdominal breathing; increase independent implementation to 10 minutes per

pain exacerbation. Reduce depressive symptoms from 2 today to 1 at discharge by replacing maladaptive thoughts related to pain and limitations with application of adaptive thoughts. Reduce anxiety symptoms 2 today to 1 at discharge by managing anxiety-provoking thoughts related to pain, functioning, and future prospects and employment of other stress management strategies. Educate claimant about constructive/adaptive coping strategies to enlarge coping repertoire and reduce reliance/use of maladaptive coping reactions. Decrease sleep problems by educating patient about appropriate sleep and increasing claimant use of proper sleep hygiene techniques; claimant will increase restorative sleep from 2-6 hours to 7-6 consistent hours per night. Conduct a realistic exploration of vocational options and develop a vocational plan commensurate with functional tolerances. Discuss and agree with termination from the chronic pain management program for noncompliance. **Long-Term Behavioral Goals:** Stabilization of active mood disturbance for over six months. Return to productive work/active lifestyle, MMI, and medical case closure. Reduce the misuse, overuse or dependence on medications for over 6 months. Increase claimant's ability to self-manage pain and related problems. Reduce/eliminate the use of ongoing health care services. **Short Term Functional Goals:** Meet 80% of program goals by discharge. Maintain at least 80% attendance during the program. Increase subjective productivity by at least 2 points. Reduce narcotic medication by at least 20%. Increase the number of outings attended in a week by 20%. Improve body mechanics from poor to fair to good by discharge. Give rating satisfaction rating of at least "satisfactory" on discharge. Increase PDL from sedentary to medium by discharge. Increase active ROM from 70% to 90% by discharge. Increase cardiovascular endurance from fair to good by discharge.

10/29/2013: Psychological Testing and Assessment Report **Present**

Medications: Benedryl dye-free allergy 25MG, Sig: PRN for sleep, Celebrex 200MG. **Vocational Status/Plan:** Testing Administered: Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: the patient scored 15 on the BDI-II, indicating mild depression. The patient's score on the BAI was 13, reflecting mild anxiety. Her responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W = 29) as well as significant fear avoidance of physical activity in general (FABQ-PA=17). **MultiAxial Diagnosis:** Axis 1: Major Depressive Disorder, single episode, moderate. Pain Disorder associated with both psychological factors and medical condition. Axis II: No diagnosis. Axis III: Injury to cervical spine left shoulder. Axis IV: Primary support group, Social Environment, Economics Problems and Occupational Problems. Axis V: GAF = 65 (current) Estimated Pre-Injury GAF = 75+. **Treatment Recommendations and Objectives:** We concur with recommendation that the claimant participate in a Chronic Pain Management Program as Ms. 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. This, it is recommended that Ms. be approved for participation in the Chronic Pain

Management Program in order to increase her physical and functional tolerances and to facilitate a safe and successful return to work.

10/30/2013: Request for 80 Hours of a Chronic Pain Management Program.

Summary: Please recall that prior treatment modalities have failed to stabilize Mrs. psychosocial distress, increase her engagement in activities of daily living, or enhance her physical functioning such that she could safely return to work. is approximately 1 year and 5 months status post injury. Her pain is chronic, persistent, and intractable at 5-9/10, depending on her level of activity. Conservative care has not been sufficient to extinguish her pain or increase her functional tolerances such that she could successfully return to her previous position. She describes limited functioning within daily, job, and familial activities. She has developed a chronic pain syndrome; the treatment of choice is participation in an Interdisciplinary pain rehabilitation program. treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this patient's pain experience, develop self-regulation skills, and facilitate a timely return to the work force.

11/04/2013: UR. Rationale for Denial: In this case, the claimant has exhausted all appropriate care including but not limited to physical therapy, injections, and surgery however the claimant continues to present with functional deficits, pain and psychological symptoms including anxiety and depression secondary to chronic pain that interferes with physical, occupational, and social functioning. The claimant has already completed a work hardening program combined with psychotherapy and guidelines do not recommend repetition of similar programs. In this case documentation does not establish how this program will provide a different or better outcome than programs provided in the past and therefore the medical necessity of this request is not established.

11/05/13: Appeal Letter. responded to the denial by stating a titration schedule for Hydrocodone was recommended as follows: Hydrocodone 5/325 TID, Hydrocodone 5/325 BID, Hydrocodone 5/325 QD and Hydrocodone 5/325 D/C. She also reported the claimant did make progress by participating in individual psychotherapy: The following reductions were noted: pain level from 6 to 3, irritability from 4 to 3, frustration from 4 to 2, muscle tension from 6 to 4, nervousness from 3 to 2, and sleep from 5 to 4. Depression and forgetfulness were maintained at 2.

12/05/2013: UR. Rationale for Denial: In this case while guidelines do suggest that prior participation in a work hardening program does not preclude an opportunity to enter a chronic pain program it is noted that repetition of a similar program is not indicated. In this case, there is limited documentation presented that demonstrates that this chronic pain management program is a significantly different program than the work hardening combined with psychotherapy that was previously completed. Outcomes from that prior program do not appear to have been successful as the claimant continues to be functioning at the sedentary level and there is limited evidence presented that shows that this program will provide a

significantly different or better outcome. Documentation does not provide documentation from the work hardening program that was completed with notation of goals and how the goals of this program differ. Therefore, the medical necessity of this request is not established.

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

The previous adverse determinations are upheld. The request for a chronic pain program is not medically necessary because it is a repetition of the work hardening program with psychotherapy, which is not significantly different. The ODG guidelines does not preclude a chronic pain program following participation in a work hardening program if otherwise indicated, however in this case there is limited documentation that the programs are significantly different, that the work hardening program was successful or the requested chronic pain program will provide a significantly different or better outcome. The documentation fails to document how the goals of for the chronic pain program differs from the completed work hardening program. Therefore, the request for 80 Hours/Units Chronic Pain Management Program is not recommended to be 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 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)**