

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]: March 12, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management – Final 80 hours, 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant stated that he sustained a work-related injury to his neck, left shoulder, left flank, L-lower extremity, and lumbar spine on xx/xx/xx. He worked light duty from xx/xxxx up to July 15, 2011, when he was terminated.

09-30-13: Prescription for Treatment. Services Requested: Evaluate and treat, functional restoration/return to work program.

10-21-13: Physical Performance Evaluation. Employment: Claimant has not been employed after his leave of absence that started 07/15/2011. Job Description: Medium Work. Current Medications: Flexeril, Tramadol, tizanidine hydrochloride. Assessments: The claimant cannot safely perform their job demands based on collaborative analysis between their required job demands

and their current evaluation outcomes. Recommendations: Claimant should continue care with their treating doctor and obtain any referrals as needed to improve condition, recommend continued participation in the multidisciplinary CPMP to address mental and psychological issues that are complicating his progress in the treatment program and ultimately to return to gainful employment.

12-02-13: Physical Performance Evaluation. Employment: Claimant has not been employed after his leave of absence that started 07/15/2011. Job Description: Medium Work. Current Medications: Flexeril, Tramadol, tizanidine hydrochloride. Assessments: The claimant has made objective movements in the following area since last evaluation: ROM, static strength, dynamic lifting, and functional specific testing. The claimant cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: Claimant should continue care with their treating doctor and obtain any referrals as needed to improve condition, recommend continued participation in the multidisciplinary CPMP to address mental and psychological issues that are complicating his progress in the treatment program and ultimately to return to gainful employment.

12-04-13: Reassessment for Chronic Pain Management Program Continuation. Present medications: Gabapentin 600mg, hydrocodone-acetaminophen 10/325mg, naproxen 500mg. Multiaxial Diagnosis: Axis I: 296.23 major depressive disorder, single episode, severe without psychotic features; Axis II: V71.09 no diagnosis; Axis III: injury to left shoulder, left knee and lumbar spine—see medical records; Axis IV: primary support group, social environment, economic problems, and occupational problems; Axis V: GAF-Current: 60, Estimated pre-injury: 80. Treatment Recommendation: recommend that the claimant continue to participate in the CPMP as he has exhausted conservative treatment yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. It is recommended that the claimant be approved for continued participation in the CPMP in order to further increase his physical and functional tolerances and to facilitate a safe and successful return to work.

12-12-13: Continuation: Chronic Pain Management Program Preauthorization Request. Previous PDL: light-medium; current PDL: medium 25-30 lbs; required PDL: medium 35-75 lbs. Summary: Please recall that prior treatment modalities had failed to stabilize the claimant's psychosocial distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. He had developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. Based on the progress made within the 10 day trial, the claimant's 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 claimant's pain experience, develop self-regulation skills, and facilitate a timely return to the work force. Thus, authorization for 80 additional hours in a CPMP appears reasonable and medically necessary for any

lasting management of his pain symptoms and related psychosocial problems, as it is the recommend treatment of choice for claimants with chronic pain syndrome.

01-21-14: Reassessment for Chronic Pain Management Program Continuation. The claimant presented for continuation in participation in the CPMP recommended by treating doctor. Present Medication: Gabapentin 600mg, hydrocodone-acetaminophen 5/500mg, naproxen 500mg. PDL: initially at light (20 dynamic, 15 frequent lbs) as of 10/21/13; improved to light PDL (25 frequent, 30 dynamic) as of 12/02/13. Diagnosis: 296.23 major depressive disorder, single episode, severe without psychotic features, 300.82 somatic symptom disorders, with predominant pain, persistent, moderate. Treatment recommendation/plan: recommend the claimant continue participation in the CPMP as the claimant has exhausted conservative treatment yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. Thus, it is recommended that the claimant be approved for continued participation in the CPMP in order to further increase his physical and functional tolerances and to facilitate a safe and successful return to work.

02-03-14: UR. As per the evidence based guidelines referenced below, total treatment duration should generally not exceed 20 full –day (160 hours) sessions. The claimant has completed 160 hours of CPMP at this time. Despite having completed 20 full-day sessions, the claimant's Physical Performance Evaluation continues at the Medium Level. Furthermore, it should be noted that the claimant has not met the targeted reduction of 75% in every active symptom. In fact, prior treatment till now, the claimant's pain, irritability, frustration, muscle tension, nervousness, sleep problems, and forgetfulness have not improved or worsened. Additionally, the claimant's depression has increased. While it is noted that additional 80 hours/units of the interdisciplinary pain rehabilitation program is requested in order to extinguish active symptoms over a long term basis, maximize functional tolerances, and propel toward a safe return to work; without an indication that the claimant is responding favorably with the additional 80 hours completed, the medical necessity to continue care is not warranted. As per the guidelines referenced, an extension beyond 160 hours must include reasonable goals to be achieved. The proposed goals do not appear to be reasonable given that lack of improvement with the most recent 80 hours of CPMP. Therefore, my recommendation in to non-certify the request for 80 additional hours of pain management.

02-07-14: Reconsideration: Continuation Chronic Pain Management Program Preauthorization Request dictated by PsyD, LPC. Claimant's Previous PDL: medium, current PDL: medium (25 frequent/30 occasional), required PDL: medium (35-75 lbs.).

02-14-14: UR. Reason for denial: The claimant has complaints of knee and shoulder pain despite surgeries. He has had 20 pain sessions. His BDI worsened from 19 to 28. His meds remained the same, other than that his hydrocodone was reduced somewhat. He was previously taking 7.5mg/day and is

currently on 5mg/day. The pain level stayed the same at 7/10. His PDL stayed the same per the 1/21 note. His BAI was reduced by one point. This claimant has had a full pain program in addition to multiple other interventions and forms of rehab. He has made minimal to no progress with any of this treatment, most recently with the pain program that ended on 1/21. Therefore, there is no indication to continue with this form of treatment. As a result, the request for 80 additional hours of pain management is not medically necessary or appropriate.

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

The previous adverse determinations are upheld and agreed upon. This claimant has completed a full pain program as well as other interventions and rehabilitation. The claimant continues to have complaints of knee and shoulder pain despite multiple surgeries. Claimant has completed 20 pain sessions. He has a worsened BDI, slightly reduced BAI, but no significant change in medication dependence or pain level. He has made minimal to no progress with any of this treatment, most recently with the pain program that ended on 1/21. Therefore, after reviewing the medical records and documentation provided, there is no indication to continue with this form of treatment. As a result, the request for Chronic Pain Management – Final 80 hours, outpatient is not medically necessary or appropriate and this request is non-certified.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <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:</p> <p>(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;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present</p>
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	<p>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 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</p>
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	<p>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) 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.</p>
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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)**