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Notice of Independent Review Decision

Date notice sent to all parties:

October 13, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

appeal chronic pain management program 80 hours/units 97799

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

Board Certified Internal Medicine

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who initially presented after a fall from height resulting in multiple left sided broken ribs. The CT scan of the chest dated xx/xx/xx revealed multiple acute left rib fractures. Small left sided pleural effusion with lower lobe atelectasis was also revealed. The clinical note dated xx/xx/xx indicates the patient continuing with complaints of chest region pain. The patient continued with left sided rib pain. There is an indication the patient had been utilizing 2 liters of oxygen via a nasal cannula. The note indicates the patient having findings consistent with hypertension, diabetes myelitis, asthma, as well as sleep apnea. There is an indication the patient's past medical history is significant for multiple back surgeries as well as a left knee replacement. The patient is currently a smoker and continues

to smoke on a daily basis. The rehab evaluation dated 04/18/14 indicates the initial injury occurred when he had a slip and fall resulting in the left sided injuries. Rib fractures were identified at the 8th and 9th ribs. The patient had initially been admitted for 2 days with worsening symptoms. The patient was subsequently admitted to a different facility where he was placed in a medical coma. The patient awoke with a portion of his colon having been removed. The patient was identified as being extremely obese with malignant hypertension, diabetes, and COPD with a continuing tobacco habit. The patient was identified as smoking 1 pack per day. The patient rated his rib pain as 4-6/10. The patient was recommended for 12 sessions of physical therapy at that time. The clinical note dated 06/05/14 indicates the patient continuing with left sided chest/rib pain. The patient rated the pain as 5/10 at that time. The patient had been undergoing physical therapy at that time. The functional capacity evaluation dated 06/30/14 indicates the patient was unable to complete the cardiovascular test. The patient was also identified as having subjective complaints that did not match the objective findings due to an exacerbation of the condition or potential lack of motivation. Upon assessment, the findings indicated the patient was unable to complete his tasks associated with his occupational choice. The psychological assessment dated 07/14/14 indicates the patient having undergone physical therapy and was continuing with individual therapy sessions. The patient scored an 8 on his BDI-2 indicating minimal depression as well as an 8 on his BAI reflecting mild anxiety. The patient scored a 38 on his FABQ-W indicating fear avoidance related to his work as well as an 18 on his FABQ-PA representing fear avoidance of physical activity. The clinical note dated 08/06/14 indicates the patient having completed a total of 12 physical therapy sessions as well as 8 individual therapy sessions. The patient has been participating in psychological testing as well. The note indicates the patient utilizing Hydrocodone for pain relief. There is an indication the patient will be titrated off of Hydrocodone through the duration of the chronic pain management program. The patient was being recommended for 80 hours of a chronic pain management program at that time. The clinical note dated 08/16/14 indicates the patient having complaints of pain at the left upper quadrant. The patient continued with complaints of right shoulder pain. The clinical note dated 08/19/14 indicates the patient continuing to be recommended for a chronic pain management program for 80 hours.

The utilization reviews dated 08/11/14 & 09/17/14 resulted in denials as the patient has been identified as having multiple comorbidities that would not likely benefit from a chronic pain management program.

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

The documentation indicates the patient complaining of ongoing left sided chest and right shoulder pain. There is also an indication that the patient had undergone an abdominal surgery with resultant partial removal of the colon. The functional capacity evaluation indicated the patient had demonstrated an inability to complete all tasks. Therefore, it is unclear as to the patient's true functional capabilities. However, there is a notation indicating the patient was unable to complete all tasks

related to his occupation of choice. The patient has been identified as having numerous comorbidities to include hypertension, diabetes myelitis, and COPD. The patient has also been identified as having a current smoking habit of approximately ½ pack per day. Given the current comorbidities, it does not appear the patient would benefit from a multi-disciplinary program of this nature. Therefore, the request is not fully indicated. As such, it is the opinion of this reviewer that the request for a chronic pain management program for 80 hours; 97719 is not recommended as medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Chronic pain programs (functional restoration programs)

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.