

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program – 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 Physical Medicine and Rehabilitation with over 18 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whom was injured on xx/xx/xx while on the job. While performing his normal work duties, he fell backwards hitting his lower back and tailbone. He was evaluated and had x-rays. In May of 2012 he had an MRI with a follow-up MRI in August 2012 which was positive. In April 2012 he completed 15 sessions of PT. He has currently been terminated from his position.

10-16-13: Initial Behavioral Medicine Assessment. Present medications: Flexeril 10mg, Gabapentin 300mg, Norco 10/325, Omeprazole 40mg, and Simvastatin 40mg. Claimant complained of low back pain 7/10, with medications 4/10 and without medication 8/10, described as stabbing and burning in his tailbone region pins and needles across his lower buttocks and burning and numbness down his left thigh. Multiaxial Diagnosis: Axis I: 300.00 Anxiety Disorder NOS, 296.21, Major Depressive Disorder, single episode, mild-due to pain and loss of functioning, 307.89, Pain Disorder associated with both psychological factors and

a medical condition; Axis II: V71.09 no diagnosis; Axis III: Injury to lumbar spine-see medical records; Axis IV: Primary support group, Social environment, Economic problems,, and Occupational problems; Axis V: GAF=62 (current), estimated pre-injury GAF=75. Recommend the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention using CBT approaches and basic self-management strategies coupled with autogenic exercises to facilitate a healthy adjustment and improve coping with their overall condition. The claimant should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 4 weeks.

02-20-14: Follow Up. Claimant is status post MRI of lumbar spine, report not available for review, and he is status post pain injection therapy to his lower back region x 4. Most recently, claimant is status post PT however at its conclusion he still has intense lower back pain. After being told there is nothing else that could be done, he has begun to look for further evaluation and treatment. He is currently in a psychological evaluation intake, 2 of 4 sessions. He has been approved for work hardening program and is now status post 8 of 10 days of the program.

03-27-14: Psychological Testing and Assessment Report. Present medication: Colace 100 mg, Flexeril 10 mg, Gabapentin 300 mg, Naproxen 500mg, Norco 10/325, Omeprazole 40 mg, Simvastatin 40 mg. Claimant presented with LBP 9/10. Diagnosis: 300.00 Anxiety Disorder NOS, 300.82 Somatic Symptom Disorder, with predominant pain, persistent, moderate. Treatment Recommendation & Objective: recommend that the claimant participate in the chronic pain management program as he has exhausted conservative treatment, yet is negatively impacted by pain and reduced functioning across activities of daily living. Thus, it is recommended that the claimant be approved for participation in a 10 day trial of the interdisciplinary pain rehabilitation program (CPMP) in order to increase his functional tolerance for a safe and successful return to work while reducing his psychosocial distress and fear avoidance behaviors as well as facilitating medical case closure.

04-18-14: Initial Office Visit Note. CC: disabling low back and intermittent leg pain worse on the right since DOI xx/xx/xx. PE: ROM: anatalgic gait using a cane to stabilize, and he is clearly stiff and protective. Right L4 dermatome dysesthesia, muscle strength: right 4/5 noted in foot dorsiflexion, nerve restriction/compression: producing mechanical low back pain and leg pain at 30 degrees. Assessment: History, physical examination, radiology consistent with diagnosis of: Annular tear with subligamentous herniation at L4-5 and disabling mechanical back and leg pain. Diagnostics or surgical recommendations: Final surgical recommendation will be made once MRI has been completed. This unfortunate patient has had the gamut of conservative treatment without improvement. Referrals/plan: 1. Physical rehabilitation: completed. 2. Pain management (interventional procedure/medications: complete. 3. Diagnostic testing: MRI is dated and probably should be repeated. Any further change at L4-5 will document this disc as a pain generator. There was no mention of weakness or dysesthesia from previous record, however the claimant presented

in obvious discomfort evidenced by the need for a cane to ambulate and weakness and dysesthesia noted in the right leg. He has a significant change as compared to previous examinations. Repeat MRI ordered. 4. Second opinion: completed. 5. F/U one month, pre-operative planning. Diagnosis codes: 722.10, 724.2.

04-24-14: UR. Reason for denial: Non-certified. There have been no significant changes in the symptoms and repeat MRI is not routinely, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg. tumor, infection, fracture, neurocompression, recurrent disc herniation).

08-12-14: History & Physical Examination Chronic Pain Management Program. CC: low back and radicular pain with bulging disc at L3-L4, L4-L5. PE: Musculoskeletal: The claimant has no AROM of his lower back secondary to the intense pain. There is diffuse paralumbar spinous muscle tenderness and spasms bilaterally. FCE recommendations are as follows: claimant cannot safely perform his occupational duties full-time, he would benefit from an 80 hour trial in the work hardening program for further strengthening and improvement of his functional capabilities, and the claimant is capable of returning to work with restrictions. Impression: lumbar disc protrusions at L4-5, L5-S1, lumbar myofascial strain, contusion; lumbar posttraumatic. Plan: 1. UDS ordered. 2. CPM program ordered. 3. Claimant medically cleared for CPM program. 4. Form-73 completed. 5. F/U one month. 6. Colace 100mg, Flexeril 10mg, Gabapentin 300mg, Naproxen 500mg, Norco 10/325.

08-21-14: Evaluation for Chronic Pain Management Program. Claimant has completed 4 individual psychotherapy sessions, 15 PT sessions and his PPE tested at the sedentary physical demand level, with current job PDL at heavy. Diagnosis: 300.00 Anxiety disorder NOS, 296.21 major depressive disorder, single episode, severe without psychotic features, 300.82 somatic symptom disorder, with predominant pain, persistent, moderate. Recommendation/Plan: recommend that the claimant participate in a 10 day trial of CPMP as he has exhausted conservative treatment, yet is negatively impacted by pain and reduced functioning across activities of daily living. Thus, it is recommended that the claimant be approved for participation in a 10 day trial of the interdisciplinary pain rehabilitation program in order to increase his functional tolerances for a safe and successful return to work while reducing his psychosocial distress and fear avoidance behaviors as well as facilitating medical case closure.

08-21-14: PPE. CC: low back pain with radiculopathy, pain 8/10. Objective: claimant unable to complete dynamic lifting test due to pain. Claimant completed assessment with a sedentary lifting category safely and should be restricted from any weight lifting and should be limited in daily activities. Assessment: The claimant demonstrates functional deficits on evaluation today that would benefit from additional medical attention, including therapy and/or diagnostic testing. Claimant was unable to complete parts of this test due to increases in acute pain levels and spasms on attempted performance of tests. Claimant was severely

limited functionally. He cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: PPE indicated the claimant cannot safely perform their occupational full time/full duty job demand PDL of Heavy, based on today's PPE the claimant's current PDL is Sedentary. He would benefit from an 80 hour trial in the CPMP to further strengthen and improve functional capabilities as well as improving pain coping mechanisms. He would benefit from continued care with their treating doctor. Plan: referral for further evaluation and treatment options.

08-29-14: UR. Reason for denial: This claimant has been attending the same facility for his rehabilitation for some time. He has also undergone 80 hours of a work hardening program. It is unclear how the requested CPMP differed from the previous treatment the claimant was receiving which appears to be run by the same staff. ODG states at the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. As this claimant has already completed an outpatient rehabilitation program and individual therapy, subsequent enrollment in a CPMP run by the same program staff would not be supported. ODG states CPMP are recommended where there is access to programs with proven successful outcomes. The claimant has undergone rehabilitation and individual counseling by the same staff and remains with a sedentary PDL and poor pain coping skills with continued opiate medication usage. Entrance into the proposed CPMP would not be supported. Additionally, cited guidelines state that negative predictors of success should be identified, and if present, the pre-program goals should indicate how these will be addressed. A negative relationship with the claimant's employer is considered one such negative predictor of success and the claimant was terminated from his place of employment following his injury. The claimant does not meet the ODG criteria for the requested CPMP. Therefore, my recommendation is to non-certify the request for 80 hrs Chronic Pain Management.

09-18-14: UR. Reason for denial: Based on the clinical information provided, the request for appeal 80 hours chronic pain management is not recommended as medically necessary. Per telephonic consultation, the claimant attended 10 days of work hardening program in 2013 and did not significantly progress. Current evidence based guidelines do not support reenrollment in or repetition of the same rehabilitation program. The claimant's date of injury is over xx years old. Current evidence based guidelines generally do not recommend chronic pain management programs for claimants who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. Therefore, the request for Appeal 80 hrs Chronic Pain Management is non-certified as it is not medically necessary and appropriate.

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

Denial of 80 hours of chronic pain management is UPHELD/AGREED UPON given lack of progress with 80 hours of a multidisciplinary work hardening rehabilitation program and individual psychological sessions with continued lowest level of SEDENTARY function reflecting no carry over and questionable compliance with a home exercise/fitness maintenance program. And lack of specific goals particularly vocational now more than xx years post injury reflects questionable motivation to change. Therefore, after reviewing the medical records and documentation submitted, the request for Chronic Pain Management Program – 80 hours/units Outpatient is denied.

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: (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</p>
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	<p>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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (Sanders, 2005) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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>
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	<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)**