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Notice of Independent Review Decision

DATE: August 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 Hours of Chronic Pain Management Program (5 x week for 2 weeks) for Elbow, Lumbar, and Wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Anesthesiology with specialty in Pain Management with over 40 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 who was injured when he fell on water on the floor and was drug by a machine while working on xx/xx/xx.

06/09/15: The claimant was evaluated. He did not demonstrate the physical abilities necessary for him to return to his previous position. He was diagnosed with sprain/strain elbow, wrist sprain/strain, lumbar region sprain/strain, and myospasms. It was recommended that he initiate a Chronic Pain Management Program. It was noted that there was an apparent level of depression and anxiety present. It was noted that sustained a work-related injury on 11/22/14 and then participated in physical therapy. Record review noted that he had suffered a recent exacerbation on 01/02/15 at work and was diagnosed with an ulnar nerve contusion. Findings concluded that his work required medium to heavy PDL, and he demonstrated the ability to perform under a lighter capacity.

06/15/15: The claimant was evaluated who requested 10 sessions of Multidisciplinary Chronic Pain Management Treatment. It was noted that since his injury, he suffered anxiety, depression, stress, and chronic pain symptoms. He had completed psychotherapy sessions but was noted to be making minimal progress due to poor coping skills, depression, anxiety, and pain complaints. It was noted that he had been compliant with treatment guidelines. Before participating in psychotherapy sessions, he reported his average levels of pain were at 7/10 and currently at 7/10. BDI II score of 12 before therapy sessions and score of 5 after completion of individual therapy sessions. BAI before

therapy was 30; after therapy 32. SOAPP-R was 0 before and after therapy. FABQ 22 on physical activity subscale and 41 on the work subscale. Treatment plan goals included returning to a higher level of functioning, decrease pain and symptomology, improve functioning, decrease dependence on healthcare system, decrease reliance on medication, improve mobility, decrease emotional distress, depression, and anxiety, improve sleep duration, aid in dealing with stress-related issues, address self-defeating thoughts, increase perception in his level of functioning, and address isolation and hostility.

06/18/15: UR. RATIONALE: Request states patient experiencing anxiety, depression, and stress. Unable to return to work. Had psychotherapy but showed minimal improvement. However, BDI went from 12 to 5 (no depression). BAI is essentially unchanged, now 32, and pain level is 7 (unchanged). SOAPP-R = 0. FABQ scores are near max on the work scale, at max on the physical activity scale. FCE indicates lumbar and right wrist pain. Also indicates a disc herniation. It is unclear if surgery has been ruled out. Has decreased lumbar ranges of motion. Validity indicates on FCE are variable. Rapid exchange grip was invalid. The patient does not appear to fit criteria for chronic pain management program in absence of discussion with requestor. Patient did have significant improvement in depression from psychotherapy, so lower levels of care do not appear to be exhausted. Further, there is neither psychological validity testing nor consistently valid functional testing on FCE. Valid psychological and functional baselines are not, therefore, established. Also, it is unclear if patient is a candidate for surgery.

06/22/15: A request for reconsideration notes that the claimant was taking prescribed ibuprofen 800 mg and Flexeril 10 mg that did not give complete relief. He had undergone physical therapy, prescription medication, and some chiropractic care, none of which had seemed completely successful in lowering his levels of pain. states that the increase in the BAI indicated that the process of the individual psychotherapy had brought forward the anxiety the patient had regarding his fear of re-injury and his failure to overcome the pain and be able to return to work. also noted that his low BDI-II scores also reflected that he was not ready for the reality surrounding his pain and his fears that had resulted to his work injury. He further states that the therapist's opinion was that the individual therapy had only made the patient's depression and fears increase but that the patient had learned not to discuss these circumstances and choose to avoid the reality that he must facet these circumstances and move forward.

07/07/15: UR. RATIONALE: There is insufficient information to support a change in determination. Per telephonic consultation, the patient is currently taking only ibuprofen and Flexeril. The patient shows depression score on the Beck scale to be within normal range and anxiety is in the severe range. There is no indication that the patient has undergone psychometric testing with validity measures to determine the severity of the psychological overlay.

07/20/15: A request for reconsideration states that the "BAI level did not drop and thus remained at a severe level and the patient ruled out a potential surgery as he wanted to address his condition without a surgical procedure that frightened him."

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

The previous adverse decisions are upheld. The information supplied does not sustain the necessity for a formal chronic pain program for the compensable injury of xx/xx/xx. The claimant has a significant number of overlying issues that are not part of the compensable injury. There is insufficient evidence that the 80 hours of the Chronic Pain Management Program will address the compensable injury rather than the psychogenic problems which appear to be the dominant issues. The ODG criteria of psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program have not been met. Therefore, the request for 80 Hours of Chronic Pain Management Program (5 x week for 2 weeks) for Elbow, Lumbar, and Wrist is not medically necessary.

ODG:

Chronic pain programs (functional	**Criteria for the general use of multidisciplinary pain management programs:** <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the

restoration programs)	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 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). (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 TEMPLATE -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)