IRO NOTICE OF DECISION TEMPLATE – WC

DATE: September 17, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Program x 10 sessions, CPT 97799

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 Physical Medicine and Rehabilitation with over 16 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 was struck in the left knee by a pipe while working.

12/17/14: The claimant was evaluated who noted that he had arthroscopic surgery of the left knee and had lower back condition since a work-related injury. Physical examination revealed no neuro deficit. reviewed an MRI dated 11/06/13 demonstrating degenerative disc disease and spondylolisthesis at L5-S1 and the L4-L5, L3-L4, and L2-L3 discs appearing normal. It was noted that he had an epidural steroid injection with no relief. The plan was to remain off work and start physical therapy.

03/27/15: The claimant was evaluated for complaints of stabbing sensation pain on the left side of body. He was noted to be emotional and "literally hysterical." He reported that his back pain had increased and rated it as 10/10. He reported problems with erections with swelling in testicles. He also reported 9/10 left knee pain. On exam, he had a depressed affect, antalgic gait, and severe distress. Range of motion of the lumbar spine was decreased with muscle spasm. It was noted that he remained very emotional and dramatic in expressing the severity and extent of all complaints. DTRs were hypoactive. Sensation was normal. SLR was negative. Left knee x-rays were negative for fracture or dislocation. MRI left knee dated 08/22/12 demonstrated extensive linear oblique tearing of the posterior horn of the medial meniscus extending to the central portion near the free margin of the meniscus and a small joint effusion without Baker's cyst formation. He underwent left medial and lateral meniscectomy and excision of foreign body on 09/18/12 and a 2nd meniscectomy on 02/23/13. MRI of the lumbar spine dated 11/06/13 demonstrated a grade 1 spondylolytic anterolisthesis of L5, bilateral facet arthrosis and moderate bilateral neural foraminal narrowing at L5-S1; a high-intensity zone present with the posterior annular fibers of the disc which may represent an annular fissure/tear that may be associated with pain; anterior bulge at L1-L2; and circumferential disc bulge at L3-L4 that touches the thecal sac with bilateral facet arthrosis. An EMG/NCV dated 02/04/15 demonstrated no lumbosacral radiculopathy. He was diagnosed with left unspecified internal derangement of the knee, intervertebral disc disorder with myelopathy, and sacral root injury. The plan was for no physical therapy at this time, prescriptions for motrin and Robaxin, await 2nd neurosurgical opinion, and request knee evaluation.

04/27/15: The claimant was evaluated for low back pain. He stated that his symptoms had improved with TENS unit and worsened with physical therapy. On exam, his mood and affect were appropriate. He had good coordination. There was no weakness or sensory deficit noted. DTRs were intact. He used a cane for ambulation and moved with difficulty. Pain was localized to the L5 junction. He had an antalgic gait. EHL strength was 5/5. Dermatomes were diminished on the left leg in L5 and S1 distribution. DTRs were 1+. SLR was positive on the left at 40 degrees. Lumbar spine x-rays were reviewed demonstrated grade 1 spondylolisthesis at L5-S1 with probable pars fracture/defect. The impression was acquired spondylolisthesis, chronic back pain, and left leg radicular pain and numbness with grade 1 spondylolisthesis at L5-S1 with probable pars fracture/defect. The plan was for lumbar myelogram with post-myelogram CT.

05/05/15: The claimant was evaluated for low back pain radiating into the left lower extremity. He stated that his pain was still severe and he was depressed. His mood was depressed and sleep was poor. He noted weakness, numbness, and tingling in the left lower extremity. On exam, he was noted to be crying. DTRs were intact. SLR was positive on the left. He was given a prescription for Neurontin and referred for FCE and psych evaluation for pain program.

05/26/15: The claimant was evaluated for MMI and impairment rating. MMI was reached on 08/13/14. Left knee impairment rating was 4% whole person impairment. Lumbar spine impairment was 10% whole person impairment. Total whole person impairment was 14%.

06/05/15: The claimant was evaluated for low back pain radiating into the left leg. He noted that his symptoms had worsened and rated it as 10/10. He ambulated with a cane and had a severe limp. He was noted to have major depression and was on Cymbalta and Robaxin, which were not helping. His social history was positive for being a current every day smoker. On exam, he had an antalgic gait and used a wheelchair for mobility. He had pain localized to the L5 junction with pain on palpation of the back at the midline and paraspinal. EHL strength was 5/5. DTRs were 1+. SLR was positive on the right and left at 30 degrees. He was noted to guard, cry, and grimace with severe pain with all physical examination testing. It was noted that 7 Waddel's signs were positive (less severe pain) when distracted. recommended posterior non-segmental instrumentation (Harrington rod technique, pedicle fixation). noted that decompression and fusion at L5-S1 with was indicated but that because of the time from injury and severe pain level with lack of nerve impingement visualized, surgery may not be successful in alleviating any of his pain.

06/22/15: The claimant was evaluated. He stated that he was seen by and that "they denied his procedure." stated that he was in disagreement with his finding of 14% IR on DD exam due to medical opinion from, and himself that he needed the back procedure. It was noted that the claimant continued to be frustrated and visibly upset and emotional about his situation. It was noted that FCE was not able to be completed due to BP and pain.

06/22/15: The claimant was evaluated for behavioral evaluation. BDI-II score of 49, within the severe range of assessment. BAI score 46, within severe range of the assessments. SOAPP-R score of 29, indicating a high risk for abuse of prescribed narcotic pain medications. FABQ-W score was 40 out of 42. FABQ-A was 42. SUMMARY: The pain resulting from his injury has severely impacted normal functioning physically and interpersonally. Patient reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain has reported high stress resulting in all major life areas. The patient will benefit from a course of pain management. It will improve his ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting his daily functioning. Patient should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists of but is not limited to daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management, and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of function as possible.

07/07/15: A Functional Capacity Evaluation was performed by. It was noted that this job specific evaluation was performed in a 100% kinesiophysical approach and demonstrated the ability to perform 12.1% of the physical demands of his job as. The return to work test items was unable to achieve successfully during this evaluation

include: Gross Motor Coordination, Walking, Sitting, and Standing. was unable to achieve any weight during lifting, carrying, pushing and pulling testing and he was not able to be classified within a Physical Demand Category. During objective functional testing, demonstrated consistent effort throughout 42.9% of this test which would suggest significant observational and evidenced based contradictions resulting in consistency of effort discrepancies, self-limiting behaviors, and/or sub-maximal effort. The overall results of this evaluation do not represent a true and accurate representation of overall physical capabilities. The functional results of this evaluation represent a minimal level of functioning for. During objective functional testing, the items that were inconsistent resulting in self limiting behavioral/sub-maximal effort included muscle testing inconsistencies, right hand grip strength inconsistencies, left hand grip strength inconsistencies, right five span grip inconsistencies, left five span grip inconsistencies, right five span versus right grip inconsistencies, left five span versus right grip inconsistencies, and left hand pinch strength inconsistencies. Throughout the objective functional testing, reported reliable pain ratings 57.1% of the time which would suggest that pain could have been considered a limiting factor during functional testing.

07/15/15: UR. RATIONALE: A recent functional capacity evaluation was documented to not be a valid study. Medical necessity for such an extensive program is not established when there is documentation of an invalid functional capacity evaluation. Additionally, the length of time that the claimant is removed from the date of injury would be considered a negative predictor for a positive response from such an extensive program.

08/05/15: UR. RATIONALE: Criteria for CPMP was not met as the recent functional capacity evaluation was documented to not be a valid study. His injury is too old according to ODG and it would be considered a negative predictor for a positive response from such an extensive program.

08/07/15: The claimant was evaluated. He stated that his pain level remained 8/10. It was noted that he was extremely frustrated that his condition continued to be unchanged. He was visibly upset and stated that he didn't "give a f what happens" to him, he just wants his pills. He stated that he was tired of the run around. He mentioned that he was seen by and was going to get him surgery and that he was the only one who was helping him at that point. He declined a full physical examination. The recommendations were for no physical therapy at this time, medications of motrin and Robaxin. Not was made that he "continues to be upset and emotionally unstable about condition and he says he just wants his MF pills so he can go." He was to follow up p.r.n. as needed for pain meds.

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

The previous adverse decisions are upheld. There was invalid FCE testing and dramatic presentations during medical office visits, suggesting questionable participation in and compliance with an aggressive multidisciplinary pain program in order to reap any functional benefit. There is also question as to previous and current medications, particularly opioid analgesics and psychotropics, and any aberrant behavior with medication use. In that vain, and given severity of psychometric measures, there is also question as to consultation with a psychiatrist regarding possible mood stabilizing medication and trial of individual psychotherapy sessions prior to consideration of CPMP so as to demonstrate compliance, willingness, and ability to participate in and maximize benefit to such a program. Also, given history of high blood pressure derailing a previous FCE, there is question as to follow up management of this medical issue so that it is not a potential barrier to participation in the physically aggressive conditioning aspect of CPMP. Therefore, the request for Chronic Pain Program x 10 sessions, CPT 97799 is not medically necessary and does not meet ODG criteria.

ODG:

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 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)**