

# Vanguard MedReview, Inc.

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March 30, 2016, Amended April 5, 2016

## IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5 x week/2 weeks- 10 sessions

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

This case was reviewed by a Board Certified Physical Medicine and Rehabilitation Doctor with over 20 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]:

XX/XX/XX: Notice of Denial. Spondylosis of L5 vertebra with grade 1 spondylolisthesis of L5 vertebra over S1, degenerative endplate changes at a few levels of the lumbar, marginal osteophytes, L5-S1 disc dessication and generalized facetar arthropathy because medical does not substantiate that these conditions are causally related to the injury of XX/XX/XX. These conditions are diseases of life, not causally related to the injury at work.

XX/XX/XX: UR. **Rationale for Denial:** This is a XX year old individual who sustained an injury on XX/XX/XX. The stated mechanism of injury was picking up a heavy piece of equipment. There has been previous treatment with oral medications, chiropractic care, physical therapy and injections. A Note, dated XX/XX/XX, includes a complaint of continued lower back pain with symptoms radiating to the left lower extremity. Pain is rated at 6/10 and aggravated with activity. Current medications include naproxen, Lyrica and Tylenol. Medications and therapy were stated to be helpful in decreasing her pain. There were also complaints of depression and anxiety. 10 sessions of a behavioral multidisciplinary chronic pain management program was recommended. A physical capacity evaluation on XX/XX/XX, states that the injured employee does not meet her requirement of function at a medium physical demand level. A decision and order on XX/XX/XX states that the injured employee had reached maximum medical improvement on XX/XX/XX with an impairment rating of 5%. The compensable injury was stated not to include abnormal findings of the lumbar spine. The ODG indicates that the criteria for participation in a multidisciplinary pain management program includes evidence that there is excessive dependence on other health care providers, spouse and family as well as withdrawal from social activities. It is also suggested that there be dependence on prescription pain medications, especially those that may develop tolerance or dependence. Furthermore, there should be evidence of previous treatment with physical therapy which has reached a plateau where no further care is beneficial. The supplied medical record does not indicate that the injured employee has any excessive dependence on others or withdraw from society. She is not prescribed any opioid pain medications and existing medications of naproxen and Tylenol are stated to be beneficial. Additionally, while there has been

previous treatment with physical therapy, this therapy treatment was also stated to be beneficial and there is no mention that additional therapy or home exercise would not lead to additional improvement. Considering the absence of this essential criteria, as well as the guideline recommendations, this request for participation in a chronic pain management program is not medically necessary.

XX/XX/XX: UR. **Rationale for Denial:** A request for reconsideration dated XX/XX/XX states that there is limited evidence of relief provided by previous treatment to include the previous psychotherapy. It also states that the injured employee has a diagnosis of chronic pain syndrome and her symptoms meet the criteria for participation in a chronic pain management program. It also states that a peer to peer discussion was not performed by the requesting provider, XX. However, this letter only addresses a small portion of the criteria for participation in a pain management program. As stated in the previous review, there is improvement with the usage of naproxen and Tylenol with improvement in pain. No opioid pain medications are prescribed. Treatment with physical therapy was stated to be beneficial and there is no mention of home exercise continuing to improve the injured employee's condition. Furthermore, a previous independent examination has stated the injured employee has sustained a myofascial strain of the lumbar spine from which symptoms would certainly not persist for over 2 years and other findings of the lumbar spine on MRI have been determined on several occasions to be unrelated to the compensable injury. Therefore, without any indication to pursue advanced treatment in a chronic pain management program, this request for 10 sessions in a chronic pain management program is not medically necessary.

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

Determination: denial of 10 sessions of Chronic Pain Management Program is UPHELD/AGREED UPON since there is lack of documentation regarding exhaustion of lower levels of rehabilitative care other than 6 individual basic PT sessions now 2 years ago and non-habituating medications (Tylenol, Naproxen and Lyrica) of unspecified frequency of usage. There is question as to compliance with basic self-directed pain modulation techniques including stretching/home exercise program, modalities such ice/heat/electrical stimulation, sleep hygiene, and activity modification. There is also lack of specific goals regarding function, particularly in light of documented "leave of absence" since XX/XX/XX and "retirement" since XX/XX/XX for "medical reasons," and DWC 73 forms dated XX/XX/XX - XX/XX/XX with return to work with NO restrictions.

**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](#).

**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)