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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Program 3 x week 10 sessions/80 units

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Board of Physical Medicine & Rehabilitation and Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
X Overturned (Disagree)
Medical documentation **supports** the medical necessity of the health care services in dispute.

Official Disability Guidelines Treatment Index, 23rd Online Edition 2018, Pain Chapter criteria was used for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX year-old XXXX who was injured on XXXX, while working XXXX. The patient reported that XXXX was XXXX. XXXX got out of the XXXX was on the site. Two hours later XXXX right leg started swelling so XXXX went to the emergency room (ER).

From XXXX, through XXXX, the patient was seen by XXXX for low back pain and neck pain. The diagnoses were sprain of ligaments of cervical spine and sprain of ligaments of the lumbar spine. XX was prescribed and magnetic resonance imaging (MRI) studies of the cervical spine and lumbar spine were ordered. The recommendation included a cervical facet block.

On XXXX, the patient was evaluated by XXXX at XXXX. The patient complained of low back pain and neck pain. The exam was unremarkable. The diagnosis was sprain of ligaments of the lumbar and cervical spine. The patient refused IV for sedation, and after a long conversation they mutually agreed to look for alternative therapies.

On XXXX, XXXX reevaluated the patient in a follow-up visit. The patient continued to complain of low back and neck pain. The patient was able to stand, sit and walk for more than 30 minutes. XXXX pain level now was 7-9/10. The patient did not want any invasive procedures. There were no significant changes in the physical exam since the last office visit. XXXX recommended chronic pain program and light duty restrictions.

On XXXX, XXXX evaluated the patient at XXXX for right hand complaint. The diagnoses were sprain of unspecified part of the right wrist and hand, abrasion of the right hand, strain of other specified muscles and tendons at ankle and foot level, right foot and abrasion of the right lower leg.

On XXXX, the patient underwent a Behavioral Evaluation at XXXX by XXXX. The current complaints included neck and lower back pain. The pain radiated to XXXX shoulders. The pain was worse in the morning. The pain was rated at 7 on an average. Activities that increased the pain included sitting too long, driving, household chores, grocery shopping, lifting heavy weight, and getting dressed and bending over. The patient reported sleeping about three to four hours at night with awakening due to pain. XXXX took naps for about two to three hours daily. XXXX was no longer able to go to the gym, play tennis, go to XXXX or XX with XXXX due to XXXX work-related injury and pain. XXXX mentioned XXXX biggest worry was XXXX back pain getting worse. XXXX expressed a desire to learn how to manage XXXX pain, and XXXX seemed motivated. XXXX appeared to be in pain during the interview and sat on the edge of the seat, then to the back of the seat and also slouched at times. XXXX current mental/emotional symptoms included a feeling of depression and anxiety secondary to the work-related injury. XXXX experienced symptoms of decreased energy, increased concerns with XXXX physical health and increased pain when XXXX was emotionally stressed out. XXXX also experienced stress regarding the treatment process of XXXX injury. XXXX tried to remain as active and involved with XXXX as possible, however, XXXX had difficulty coping with XXXX pain and adjustment difficulties related to XXXX injury. The Beck Depression Inventory II (BDI-II) score was 9, The Beck Anxiety Inventory (BAI) score was 5, The Screener and Opioid Assessment or Patients in Pain – Revised (SOAPP-R) score was 17, The Fear Avoidance Beliefs Questionnaire (FABQ) score was 39/42 (Work Scale) and 24/24 (Activity Scale). The mental status exam revealed the mood was depressed but euthymic at times. The recommendation was 10 trial sessions of behavioral multidisciplinary chronic pain management program (CPMP) since the patient had not been stabilized enough to enhance coping mechanics to more effectively manage pain and achieve success in rehabilitation.

A functional capacity evaluation (FCE) was completed on XXXX. The reported pain level was 7. It was noted that during evaluation, the patient was unable to achieve 100% of the physical demands of XXXX job/occupation. The limiting factors included anxiety, inadequate strength, increased pain, self-limiting behaviors and sensation and submaximal effort.

On XXXX, XXXX submitted a preauthorization request for 10 sessions/80 units of chronic pain program.

On XXXX, XXXX, performed a utilization review and denied the request for 80 hours of chronic pain management program (CPMP). Rationale: "*Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, chronic pain management program (CPMP) is recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "delayed recovery". The patient demonstrated the ability to perform within the sedentary physical demand category (PDC) which failed to meet the job requirement of a heavy PDC. The patient showed minimal psychosocial barriers as evidenced by Beck Depression Inventory (BDI-11) score of 9, Beck Anxiety Inventory (BAI) score of 5. Although the patient failed to meet the job requirement at a heavy PDL, the psychosocial barriers for depression and anxiety fell under a minimal category. The guideline indicated that chronic pain management program is used when there is a need for more intense psychological treatment like cases with moderate to severe psychological barriers. Based on the information provided, guidelines reviewed and lack of successful peer discussion, the request is not medically supported at this time and thus, non-certified.*"

A correspondence dated XXXX, from XXXX notified XXXX about the denial.

On XXXX, XXXX appealed the denied service. XXXX stated the patient failed to meet XXXX physical demands as cited on the FCE. XXXX scored high for Fear Avoidance with activity and work – therefore a Work conditioning program would not be appropriate due to high fear. The patient had sleep disturbances and also listed Depression and Anxiety symptoms as shown on page 2 of the Behavioral Evaluation dated XXXX. The patient also had a high average pain report of 7. XXXX had a fear of needles/injections; therefore, XXXX would like an alternative to learn to lessen XXXX pain and manage it and become stronger so that XXXX can go back to work as XXXX reported struggling with finances. XXXX felt that the patient met ODG.

On XXXX, XXXX submitted a preauthorization request for 10 sessions/80 units of Chronic Pain Program.

On XXXX, XXXX, completed a reconsideration and upheld the denial for 80 hours of CPMP. Rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the appeal request for 80 Hours of Chronic Pain Management Program is not medically necessary as the psychosocial barriers for depression and anxiety still fell under a minimal category."*

On XXXX, XXXX was notified about the denial.

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

The ODG cites the criteria for the general use of multidisciplinary pain management programs, including chronic pain management programs. The criteria has been met and outlined appropriately in the XXXX note Behavioral Evaluation and Request for Services. The ODG criteria, as outlined below in bold face, does not indicate that it must be severe. In fact, the interpretation is that you must test to identify pertinent areas that need to be addressed during the program to improve the ultimate goal of returning to work. Therefore, the request is certified and is medically necessary.

"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 2 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 3 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, 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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES