AccuReview
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December 21, 2017

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional 10 Sessions/80 Units of Chronic Pain Program 3x/Week 97799 CP

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

This physician is Board Certified in Anesthesiology and Pain Management with over 15 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]:

XXXXX: Function Capacity Evaluation dictated by XXXX. Summary/Impression: The claimant appeared having a difficult time walking on the Treadmill for 5 minutes at speed 1.5 MPH and XXXX was unable to complete the full 15 minutes. XXXX was able to continue with the evaluation. XXXX appeared having difficult time bending for 10 times and was unable to complete the full 10, XXXX was unable to do squat lift, power lift, shoulder lift, overhead lift, and unilateral lift with 25-pounds. Upon functional observation, it should be considered that the claimant did perform with maximum effort.

XXXX: Follow up Patient Narrative dictated by XXXX. Claimant is currently on modified duty with no new symptoms. CC: neck pain – posterior neck/trapezius muscles. DX: strain of muscle, fascia and tendon of lower back, subsequent encounter, strain of muscle and tendon of unspecified wall of thorax, subsequent encounter, radiculopathy of cervical region, radiculopathy of lumbar region. Expected MMI XXXX, and XXXX is making slow progress in physical therapy,

XXX: MRI of the thoracic spine without intravenous contrast dictated by XXXX. Impression: 1. No thoracic vertebral body compression fracture deformity or spondylolisthesis. Thoracic cord signal is normal. No acute or subacute fracture. Incidentally noted reversal of the cervical lordosis on the sagittal scout images, suggestive of muscle spasm. 2. Less than 2 mm right central disc

protrusion/herniation at T9-T10, producing partial thecal sac effacement without significant neural compromise. 3. Less than 2 mm left central disc protrusion/herniation at T8-T9, producing partial thecal sac effacement without significant neural compromise. 4. Shallow annular bulge of less than 2 mm at T10-T11 and T11-T12 without cord flattening or significant neural compromise at either level. 5. Mild facet arthropathy and ligamentum flavum hypertrophy at T8-T9 through T11-T12. No disc herniation or significant neural compromise noted involving the remaining thoracic intervertebral disc levels.

XXXX: Office Visit dictated by XXXX. CC: neck pain, stays at 6 and never goes away but does get worse, radiating pain in thoracic area and neck between shoulder blades and left pinky finger has tingling sensation. PE: cervical spine: soft tissue palpation on the right tenderness of paracervicals, the trapezius, and the rhomboid. ROM: rotation of the left decreased and the right decreased and flexion decreased, extension decreased, and pain elicited by motion; thoracic tenderness. Assessment/Plan: There is no evidence of disk herniation or anything that is going to require surgical intervention on the MRI, therefore, referring to professional pain program, multidisciplinary, and we are going to refer him to XXXX for pain program. 1. Neck sprain – referred to pain management, 2. Thoracic back sprain.

XXXX: Office Visit dictated by XXXX. CC: low upper back pain MRI thoracic spine facet hypertrophy T9-T12. Assessment: Sprain of Ligaments of thoracic spine. Plan: Claimant needs a chronic pain program, and would benefit from thoracic facet blocks at T9-10 and T10-11.

XXXX: Office Visit dictated by XXXX. CC: low upper back pain. Pain 7-9/10 constant aching pain, soreness, throbbing, stiffness, shooting pain and burning. Pain program and facet block both denied. DX: sprain of ligaments of thoracic spine.

XXXX: Progress notes Cardiovascular Exercise dictated by XXXXX. Claimant arrived XXXX and did not perform activities. Learning to relax and lessen pain in therapy however, appeared hesitant to do all the exercises.

XXXX: Progress notes Group Therapy dictated by XXXX. Pain reported 7/10 and taking pain medications: ibuprofen 800mg and tramadol 50mg.

XXXX: Progress notes Group Therapy dictated by XXXX. Claimant reported to use XXXX TENs unit that did give improvement.

XXXX: Progress notes dictated by XXXX. The claimant is currently performing more physical activities and can perform up to 25 minutes on treadmill and cardiovascular activity on the bike for 30 minutes. It is recommended that the claimant participate in an additional 10 sessions of chronic pain management to increase XXXX cardiovascular tolerance up 45 minutes uninterrupted, an increase of strengthening up to 70-80 pounds.

XXXX: Progress Summary dictated by XXXX. Summary: the claimant is continuing to progress toward XXXX goals and ability to improve in the daily activities of XXXX life. XXXX participates in the written assignments and is willing to share XXXX thoughts with the group members. Additional sessions would help him form a routine and schedule. XXXX is learning adequate coping mechanisms to deal with the multifaceted deficits that are occurring as a response to XXXX injury. The claimant demonstrated the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce. XXXX would benefit with continued group sessions to better manage and use XXXX coping skills. Additional sessions are necessary to the motivation and education XXXX is receiving, which are helping him to redefine XXXX life and return him to optimal functioning. Requesting 10 additional sessions of the Chronic Pain Management

Program at this time.

XXXXX: UR performed by XXXX. Reason for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced did not show significant gain. There was no change in anxiety, no change in perception of pain and no change in ability to alter XXXX PDL status. XXXX remained in the light to medium PDL ability despite a trial of up to 80 hours of prior rehabilitation with multidisciplinary care. Guidelines do not support maximum recommendations as an entitlement as there must be proven objective efficacy to suggest a need for continuation. Exceptional factors are not present.

XXXX: Office Visit dictated by XXXX. Claimant denied for further chronic pain program and is a little apprehensive about the thoracic facet blocks, depressed mood.

XXXX: Office Visit dictated by XXXX. CC: upper back pain. Pain is 7-9/10 constant aching pain, soreness, throbbing, stiffness, shooting pain and burning with nothing making it feel better. Interspinous tenderness in the thorax. DX: sprain of ligaments of thoracic spine. Will perform facet block under local as XXXX has no ride available.

XXXX: UR performed by XXXX. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Documented objective evidence of efficacy and psychological gains remains insufficient to warrant continuation of treatment in a specialized Chronic Pain Program, as opposed to more conventional treatments, such as physical therapy.

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

The previous adverse determinations are upheld and agreed upon. Based on records submitted for review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Documented objective evidence of efficacy and psychological gains remains insufficient to warrant continuation of treatment in a specialized Chronic Pain Program, as opposed to more conventional treatments, such as physical therapy. Therefore, this request for Additional 10 Sessions/80 Units of Chronic Pain Program 3x/Week 97799 CP is non certified.

Per 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 more than 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.

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)**