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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program of 80 hours

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX XX XX who was injured on XX was walking up the stairs and shoe caught the end of the step and bounced back causing to fall forward on right side, hitting right arm on the step. XX crawled up and held on to the rail to make it XX. At the end of the day, XX experienced pain in head, neck, upper back, right arm, right shoulder and right hand.

On XX, the patient underwent a magnetic resonance imaging (MRI) of the cervical spine at XX. The study showed straightened cervical lordosis. No fracture or destructive osseous lesions were seen. There was normal craniocervical junction and normal cervical spinal cord. There was mild degeneration of discs from C4-C5 – C6-C7 with nuclear dehydration and spondylosis. At C4-C5, there was a 2-mm diffuse spondylitic protrusion with moderate right foraminal narrowing due to 3 mm focal osteophyte/disc complex. At C5-C6 and C6-C7, there were 1.5 mm diffuse posterior protrusions with mild right foraminal narrowing at C5-C6 and mild bilateral foraminal narrowing at C6-C7. There was normal cervical central spinal canal without stenosis. There was mild multilevel uncinate joint and facet joint arthrosis.

From XX, through XX, physical therapy notes from XX were documented. The patient attended a total of XX sessions.

On XX, XX, M.D., evaluated the patient for right arm, shoulder and hand pain. The pain level was 8/10. The current medications included XX XX, XX, and XX. The past medical history was notable for diabetes. On exam, the cervical spine had decreased range of motion (ROM) in all planes. The muscle spasm along the paraspinal muscles remained the same. Trapezius muscle spasm was noted on the right side. The tenderness remained the same. The right shoulder exam showed diffuse tenderness. The ROM abduction increased, and flexion remained the same. The right elbow exam showed the edema remained the same. The ROM during the flexion and extension remained the same, and tenderness over the lateral epicondyle remained the same. Wrist flexors remained weak. The extension, arm flexion, extension, supination and pronation remained weak. The right hand/wrist exam remained the same. Muscle testing revealed the grip strength remained weak, and the extension strength remained weak. The radiographs of the cervical spine, right shoulder, right elbow and right hand/wrist dated XX, were negative for fracture or dislocation. The diagnoses were cervical spine sprain, right shoulder joint derangement, right upper arm contusion, right forearm contusion, right wrist/hand sprain and right hand contusion. The plan was to continue PT and medications and refer the patient for epidural steroid injection (ESI).

On XX, XX, M.D., evaluated the patient for neck pain radiating to the right upper extremity. On exam, the patient appeared anxious. XX moved all extremities. XX asked for water, took a sip, but was not better. XX asked for an ambulance. EMT came and suggested to that it was a panic attack. The patient wanted to go to the emergency room (ER) at the hospital and was taken on a stretcher. The diagnosis was a cervical sprain.

On XX, XX saw the patient for neck pain radiating into the right upper extremity. The patient was able to stand for less than 15 minutes, sit for less than 15 minutes and walk for 30 minutes. The pain level now was 7-9/10. Per XX, had had a panic/anxiety attack. XX stated that given the negative electromyography (EMG), the findings of degenerative change on magnetic resonance imaging and clear anxiety/depressive symptoms, was a candidate for a chronic pain program. A functional capacity evaluation (FCE) and psychological evaluation were ordered.

On XX, XX, Ph.D., performed a XX. The patient's psychological symptoms appeared to be marked by the following: Sadness or down feelings, decreased appetite, hopelessness, insomnia, decreased energy, frustration, irritability, inability to get pleasure, increased sensitivity, crying episodes, decreased motivation, helplessness, decreased libido, discouragement about the future, short temper, feelings of inadequacy, inability to relax, muscle tension, difficulties adjusting to injury, panic, restlessness, rapid heart rate, nervousness/jitter/shaky, difficulty breathing, fear of re-injury, concentration difficulties, increased concerns about physical health and increased pain with tension or when emotionally upset. The patient reported sometimes took more medication than prescribed. XX was taking XX and XX for mood disorders or depression and anxiety. XX had been having anxiety since work-related injury. XX reported a history of depression and anxiety due to job and co-workers. XX stated moods were under control until work-related injury and pain had triggered it. XX reported co-workers made life miserable for some time. XX was being treated for anxiety and depression. On exam, the Beck Depression Inventory II (BDI-II) score was 48, within the severe range of assessment. The Beck Anxiety Inventory (BAI) was XX, within the XX of the assessment. The Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R) was XX, indicating XX for abuse of the prescribed narcotic pain medication. The Fear-Avoidance Beliefs Questionnaire (FABQ) was XX in work scale (XX) and XX in Activity Scale (High). XX opined the patient met the criteria for the general use of multidisciplinary pain management program according to Official Disability Guidelines, chronic pain chapter.

On XX, the patient underwent an FCE at the Back and Neck Clinics. The patient appeared to have another anxiety attack, and so XX was brought into the room. XX was able to perform the reaching task only one time, but due to anxiety was unable to stand due to pain. XX terminated walking, above shoulder reaching, squatting, sustained squatting, sustained kneeling and repetitive kneeling due to anxiety and safety concern. It was noted during objective functional testing, the patient demonstrated consistent effort throughout XX% of the test which would suggest the patient put forth full and consistent biomechanical and evidence-based effort during this evaluation.

On XX, XX, Ph.D., performed an Adverse Determination and denied the request for 80 hours of Chronic Pain

Management Program with the following rationale: "*This is the request for 80 hours of CPMP. This is my first review of this patient. The patient had a slip and fall injury; had head, neck and right arm and wrist pain; had a panic attack due to pain. Psych report lists over twenty symptoms including hopelessness, tension and panic, takes XX 50, XX 5 mg, XX XX and XX, has a pre-injury history of depression and anxiety due to job and co-workers, has had suicidal thoughts, has not had any inpatient psych treatment. BDI = 48 extreme depression, BAI 43 extreme anxiety, FABQ scores are near maximum, SOAPP Score shows extreme potential for aberrant medication taking. There is no broadband psychological testing which in this case is critical due to the extreme score on single measure psych tests and pre-existing psychological problems. Absent such testing the validity of these individual measures and their relationship to injury is questionable. Lifting on FCE was 0 pounds. PDL is SEDENTARY and job PDL is MEDIUM. Heart rate did not vary during functional testing, indicating poor effort. COV for right hand grip strength (affected side) showed extremely invalid test….. No validity testing was given for psych issues. XX said that most of anxiety started by losing job. XX had just switched departments when got injured. XX says cannot breathe because pain is so high. Spoke with XX and MA who did the FCE. I asked about the COV on the hand grip. XX said that when the patient did the hand grip it increased pain. Heart rate did not vary during testing but did when became anxious. This request is not within Official Disability Guidelines. In my opinion, an adequate and thorough evaluation (Official Disability Guidelines guideline 3, below) has not been performed. The FCE has an unacceptable coefficient of variation, and heart rate did not rise during functional activities, indicating the patient did not put forth good effort on the FCE. The psych testing shows pre-existing psych issues and extreme scores on individual psych tests, but the absence of a broadband psychological test that would include validity measures (such as MMPI-2, BHI-2 or MBMD) does not allow one to make any conclusions about the extent to which patient reports might reflect symptom exaggeration. Given these concerns I cannot approve this request.*"

On XX, XX/XX completed an appeal/reconsideration. It stated "*Reviewer, XX Ph.D., reported that Psych testing showed PRE-EXISTING psych issues? Patient has developed anxiety symptoms as a result of work-related injury and pain. The patient did not LOSE job, as reviewer stated. After the patient became injured at work, XX retired with the XX. The patient would like a better quality of living and learn how to manage pain which seems to trigger anxiety as viewed in the interview and during the FCE. #3 in the ODG for a Functional Restoration Program and a Chronic Pain Management Program states that Patient should have elevated scores on Psych tests. Patient was tested with the BDI, BAI, SOAPP-R and the FABQ which is standard for pre-requisite of a pain program. Through Physical Conditioning and Cognitive Behavioral treatment combined in the program, patient can learn to manage pain and recognize irrational beliefs about pain along with education about pain. Patient meets ODG."*

On XX, XX, M.D., reviewed the request/reconsideration for 80 hours of CPMP and upheld it. Rationale: "*The records indicate a psychiatric assessment was completed, it is noted this individual sustained a slip and fall injury dating back to XX. During the course of this treatment, the records indicate this individual retired from position. However, there continues to be issues with anxiety and depression. Numerous other psychiatric symptomatology are noted. However, as identified in the Official Disability Guidelines the first criteria for such programs is documentation of proven successful outcomes. This particular information is not presented for review. Additionally, this does not appear to be excessive dependence on healthcare providers, this is a retired individual in the overall physical capacity is a non-issue, and it is not clear what other previous options have been attempted for treating this chronic pain. Additionally, further medical documentation was reviewed. Specifically, the intake assessment is noted. However, there continues to be no specific data concerning the utility of this program. Without the noted outcome measurements this is not supported. Therefore, there is insufficient clinical data presented to support this request."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The request is for eighty hours of chronic pain management (CPMP) yet the only medications are XX 50,XX 5 mg, XX, XX and XX which are minor and do not merit CPMP. In a addition, an FCE, in my opinion, indicates submaximal effort as noted by heart rate unchanged during activity and 0 pound lift. also had negative electromyography (EMG) and only chronic findings of degenerative change on magnetic resonance imaging, The patient is noted to have preinjury psychologic issues and in my opinion does not qualify per ODG for Chronic Pain Management Program. The request does not support medical necessity.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**