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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 Hours of XX Program between XXXX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Anesthesiology with over 10 years of experience, including Pain Management

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 XXXX who sustained an injury on XXXX while XXXX.

XXXX. Claimant complained of XX XX and XX pain. The exam was unremarkable. Claimant was diagnosed with sprain of ligaments of the XX and XX XX.

XXXX. Claimant complained of XX XX and XX pain. The claimant was unable to stand, sit and walk for more than 30 minutes. XXXX pain level now was 7/10. No changes in the PE since the last office visit. Recommended chronic pain program and light duty restrictions.

XXXX: Functional Capacity Evaluation by **XXXX**. The physical demand level was noted sedentary. XXXX job PDL was noted heavy.

XXXX: Designated doctor evaluation by **XXXX**. Claimant failed to meet XXXX physical demands as cited on the FCF. XXXX scored high for fear Avoidance with activity and work. Therefore, a work conditioning program would not be appropriate due to high fear. Claimant reported sleep disturbance and also listed depression and XX symptoms.

XXXX: Notice of Independence Review Decision by **XXXX**. The previous adverse determination was overturned and stated that the medical documentation supports the medical necessity of the 80 hours of Chronic Pain Mgmt Program.

XXXX: Progress notes by **XXXX**. Claimant started chronic pain management and completed 7/10 authorized sessions. After 7 sessions, XXXX pain score average was 7/10 which was unchanged from the initial pain score of 7/10 before entering the program. XXXX reported that before entering the program XXXX was taking the medications as prescribed. However, after completion of the group therapy sessions of the program, XXXX reported that XXXX had lessened XXXX medication intake to an as needed basis. XXXX continued report that XXXX was managing XXXX medications and pain better than before. XXXX was beginning to understand that XXXX was only one who could decrease XXXX pain level and manage XXXX stress and XXXX appeared to be working to improve XXXX life. XXXX was able to lift 15 lbs from the initial 10lbs.

XXXX Progress notes by **XXXX**. Claimant has completed 7of 10 authorized sessions. Claimant reported taking less medications to a as needed basis. It is noted that the claimant is able to lift up to 15 lbs of strengthening, and is able to perform pushing, pulling with 15 pounds. After completion of sessions in the chronic pain management program XXXX scored 13 on XX Depression Inventory and 7 in XX XX Inventory.

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XXXX: Progress notes by **XXXX**. The claimant was in for the last day in group therapy sessions/program. This was 10/10 attendance.

XXXX: Designated XX by **XXXX**. The claimant reached max medical improvements on **XXXX** with whole person impairment of 0%.

XXXX: Office visit report by **XXXX**. Claimant complained of XX pain. XXXX reported that XXXX pain level is 4-6/10 with 7-9/10 at worst and 4-6/10 at best. XXXX describes XXXX pain as constant swelling, aching and sore. XXXX reported that medications intake alleviates pain. The was diagnosed with sprain of ligaments of XX XX and sprain of ligaments of the XX XX. As per affiliated review, there has been a non-certification for 80 hours of Chronic Pain Mgmt Program on **XXXX**. The reviewer noted despite records stating the claimant had good program participation, the claimant actually missed 30% 3/10 of the scheduled appointments, hardly a good participation rate.

XXXX: UR performed by **XXXX**. Rationale 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. In this case the claimant already participated in a total of 10 chronic pain management program sessions. There was a minimal improvement in the current PDL at light from sedentary PDL as noted in the increase to 15 pounds from 10 pounds of strengthening despite the 10 sessions completed. However, XXXX pain score remained 7/10 while XXXX BDI-II score was 13 from a score of 9 and BAI score was 7 from 5. The objective efficacy of treatment was not fully established to support continuing the program at this time. Based on the information provided, the request is not medically supported at this time and thus,

non-certified.

XXXX: UR performed by **XXXX**. Rationale for denial: Based on the clinical information submitted for this review, this request is not medically necessary. The appeal request for 80 hours of chronic pain management program is not medically necessary as there was limited objective evidence to establish efficacy and to validate significant improvement from prior program to support the additional sessions.

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

Based on the records submitted and peer-reviewed guidelines, this request is non-certified. The appeal request for 80 hours of chronic pain management program is not medically necessary as there was limited objective evidence to establish efficacy and to validate significant improvement from prior program to support the additional sessions. Therefore, this request is non-certified.

The request for 80 Hours of Chronic Pain Management Program between XXXX is found to be not 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 XX, 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. 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 XX XX 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)**