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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed 10 sessions of Chronic Pain Management (97799 CP)

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

REVIEW OUTCOME

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

- Upheld (Agree) (Disagree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
840.9	97799	CP	PROSP	10					Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old female who sustained a work-related injury on xx/xx/xx while working for . Patient was performing her usual job duties when she injured her right upper extremity while helping to lift a 6' by 4' banana rack. Records indicate she felt immediate pain in the right shoulder followed by pain that developed in the right elbow and wrist. She was taken to the ER,

where she was diagnosed with tennis elbow and released. Patient attempted to return to work for one week with restrictions, but was unable to do so due to pain interference. Patient saw Dr. on 11-06, and established treating. (There are no records of the intervening time period). She also began seeing Dr. , D.O. , for pain management, and was referred to the , where she continued to report high levels of pain, in the 9-10/10 range. Medication history includes Hydrocodone, Amitriptyline, Ultram, Naproxen, and Cyclobenzaprine. Patient is currently denied these meds by the insurance carrier. She has not returned to work, and her work status is listed as "Terminated/off work".

From June 2006 to February 2007, patient received MRI's of the right shoulder, wrist, and elbow. MRI of the right shoulder indicated lateral down sloping of the acromion which is predisposed to rotator cuff pathology. MRI of the right elbow indicated mild distal triceps tendinosis without evidence of tear or bursitis. There was a very small non specific joint effusion. MRI of the right wrist indicated small distal radial ulnar joint effusion and mild intermediate signal intensity in the peripheral TFCC. Initial diagnosis was right shoulder strain/sprain.

On 10-09-7, patient was referred for orthopedic consult with Dr. , and received medication management. Over the years, Dr. has requested diagnostics to include EMC/NCS and a TESLA MRI, as well as requesting surgery, but has been denied all his requests. Office note of 2-19-08 states "Patient has been denied critical diagnostic study again, secondary to "lack of information", so a report of today's visit and chart review will be sent ASAP. This will include patient's 2 year history of pain, dysfunction, and conservative care." His last note of 4-08-08 states "Patient has been denied surgery based on ridiculous claims; for example, reviewer states patient needs more conservative care, though she has consistently been denied PT". An arthrogram was ordered at this visit, but records indicate it was never accomplished.

On 1-15-8, patient was recommended for Work Hardening program by Dr . This was denied in IRO. IRO reviewer noted several different functional capacity tests, one of which recommended a work hardening program, and one that stated patient showed "very poor effort". He did not explain the specific reason for his denial, but just stated that ODG criteria were not met.

Patient was eventually diagnosed with right shoulder/elbow/wrist strain/sprain, Pain disorder due to general medical condition and psychological, adjustment disorder with mixed anxiety and depression, right shoulder internal derangement/impingement syndrome, adhesive capsulitis of right shoulder, rotator cuff syndrome, and lateral epicondylitis of right elbow. Current medications include Lexapro, Respiridal, Trazadone, and Tegretol. Records indicate patient has a pre-existing bipolar diagnosis, is currently indigent, and receives services and her medications through community outreach.

Patient was recently approved for 6 IT sessions, which she has successfully completed. During this time, she made gains in reducing reported family discord, vocational worries, anxiety, and sleep disturbance. Her average pain level is now a 7/10, on a constant basis. BDI has decreased from the severe to the moderate range. At the time of the initial eval for CPMP, claimant was exhibiting the following injury-related symptoms: Right UE pain that is rated, on average, as an 7/10, difficulty sleeping, decreased ADL's, decreased recreational activities/hobbies, decreased strength, stamina and endurance, increased irritability and anger, depressed/anxious mood, and disability mindset. FCE shows patient to be at a Sedentary PDL, and would need to be at a Medium PDL to return to her previous job. Patient is not currently working and has been terminated from , but records indicate she wishes to return to work and appears motivated, per her participation in individual therapy, to increase her overall functioning in order to do so. Patient has been referred for CPMP by her treating physician and goals include: reduction in depressed/anxious symptoms, decreased subjective pain levels associated with ADL's and work activities, increased activity and pain tolerance, reduced pain to 2/10, implementation of cognitive-behavioral pain management coping strategies, and improved PDL for return to work. This request is for the initial 10 days of a chronic pain management program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES,

THEN INDICATE BELOW WITH EXPLANATION.

Patient has continued right upper extremity pain complaints, and has received evaluations from her treating medical doctor, a referral specialist osteopath, a psychotherapist, and surgeon, all of whom agree patient's only alternative at this time is participation in a CPMP. Previous methods of treating the pain have been unsuccessful, and patient has been denied surgery. Patient appears to have followed all doctor recommendations to this point, and reports motivation to continue to follow recommendations that would improve her so she can go back to work.

Per ODG, patient has a significant loss of ability to function independently resulting from the chronic pain, both physical and behavioral, and there are no reported contraindications in the records available for review that have not been discussed with the patient. Per ODG, patient has followed a stepped-care approach to treatment, and is now in the tertiary stages of her treatment. The denial based on a report stating patient gave poor effort seems contradicted by all of her primary and secondary care providers. It has been accepted (via the approval for individual therapy) that patient has an injury-related pain disorder, and it is not unusual for these patients to brace and guard, and have beliefs that they should avoid movement that increases their pain.

TDI-DWC has adopted the ODG treatment guidelines as the standard for non-network workers' compensation claims. Based on ODG criteria, the current request for initial trial of 10 days is deemed medically reasonable and necessary. Twenty days is generally established as meeting the minimum requirements for most patients, given that subjective and objective functional improvements are happening.

ODG recommends CPMP for this type of patient, and ODG supports using the BDI and BAI, among other tests, to establish baselines for treatment. [Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 2001.](#)

See also:

Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.

Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines for low back problems](#). ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

Criteria for the general use of multidisciplinary pain management programs:2008

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note [functional improvement](#);
- (2) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;
- (3) The patient has a significant loss of ability to function independently resulting from the chronic pain;
- (4) The patient is not a candidate where surgery or other treatments would clearly be warranted;
- (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including

disability payments to effect this change; & (6) Negative predictors of success above have been addressed. Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Total treatment duration should generally not exceed 20 sessions. ([Sanders, 2005](#)) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The patient should be at MMI at the conclusion.

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. ([WCRI, 2005](#)) ([Joling, 2006](#)) ([PERI, 2005](#)) ([Smith, 2001](#)) ([Stover, 2007](#)) Delayed recovery has been associated with delayed referral to nurse case management. ([Pransky, 2006](#))

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

- XX ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES