CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 12/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of chronic pain management

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

REVIEW OUTCOME

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 1-15-08 , MD., Pain Management follow up.
- 1-18-08 Surgery performed by , MD.
- 4-3-08 Surgery performed by , MD.
- 9-2-08 , MEd, LPC., Mental Health Evaluation.
- 9-5-08 , MD., Pre-Authorization Request for - 20 sessions.
- 9-23-08 , DC., Utilization Review.
- 10-8-08 , MD., Request for Reconsideration.
- 10-13-08 , DC., Utilization Review Reconsideration.
- 12-3-08 , MD., Letter to Fellow Doctors.

PATIENT CLINICAL HISTORY [SUMMARY]:

1-15-08 MD., Pain Management follow up. The claimant continues with right knee pain graded on a VAS score of 9/10. The claimant is planning to have her right knee arthroscopy performed this Friday. The claimant states that the medications prescribed for sleeping (Lunesta) gave her nausea. The claimant is in for medication refill. The claimant examination of the right knee is essentially unchanged since the visit of 12-18-07. Impression: Right knee internal derangement, sleep deprivation, history of left wrist internal derangement. Plan: Increase her Vicodin to 10 mg one po q8h p.r.n pain. This is in anticipation of the claimant surgery this Friday. The claimant was also provided with a prescription for Ambien 5 mg one po qhs p.r.n sleep.

1-18-08 Surgery performed by , MD. Partial medial mensicectomy of the right knee, chondroplasty, femoral trochlea - separate compartment. Removal of loose body to the right knee.

4-3-08 Surgery performed by MD. Surgery to the left wrist. Report not complete.

9-2-08 , MEd, LPC., Mental Health Evaluation. The claimant was referred to assist further in assessing difficulty with pain and overall adjustment issues related to this claimant's injury, to determine whether mental health factors are inhibiting treatment benefit and ability to return to work and to determine if the claimant would be suitable for and would benefit from a Pain Management Program. A clinical interview and testing was conducted. The claimant underwent McGill pain questionnaire, Brief Pain

Inventory, Oswestry Disability Index, Beck Depression Inventory II, and Beck Anxiety Inventory II. Diagnosis: AXIS I: Pain disorder associated with both psychological factors and general medical condition, major depressive disorder-moderate. AXIS II: No diagnosis. AXIS III: Work related injury to the left wrist and right knee. AXIS IV: Physical, psychological, occupational, social and financial problems. AXIS V: GAF - 58 (current). Conclusion and recommendations: The claimant was involved in a work related injury on xx/xx/xx where she injured her left wrist and right knee. She have been treated with right knee surgery, left wrist surgery, physical therapy, medication and brief course of Individual psychotherapy. Despite these levels of care, the patient continues to report high levels of pain and has been unable to return to work. She reports that her pain significantly impairs her ability to function physically, psychologically, interpersonally, and vocationally. In addition to her chronic pain, the claimant reported symptoms of depression and anxiety. The claimant reported good pre-morbid adjustment prior to her injury and stated that her level of functioning has been significantly impacted. The claimant manifests a symptom pattern highly consistent with Pain Disorder associated with both Psychological Factors and a General Medical Condition and Major Depressive Disorder. On the basis of the above history and psychological findings, it is clear that the claimant's injury has caused the above diagnostic condition. She is facing significant, permanent loss of functioning and readjustment. Based on the claimant's history and response to the test materials, she demonstrates symptoms of depression that contribute to the etiology, maintenance, and intensity of pain and the ability to cope with the chronic pain. The claimant reports that she has experienced mixed results from the previous treatments she has received in relieving her pain. She is interested in learning how to reduce the need for medications, manage her pain more effectively with the use of self-help skills such as relaxation techniques, learn how to manage her stress, reduce and manage her psychological symptoms. The patient’s response to the injury may presently interfere with her ability to benefit from treatment and may limit her ability to return to work.

9-5-08 , MD., Pre-Authorization Request for Chronic Pain Management - 20 sessions. The claimant requires the medical services that are only available in a CPMP in order to treat the psychological component of her injury, achieve clinical MMI, return to gainful employment, and achieve case resolution. We therefore request 20 sessions of the chronic pain management program for the claimant.

9-23-08 , DC., Utilization Review - Adverse determination for Interdisciplinary Chronic Pain Management Program, 20 sessions, 5 hours per day for chronic pain of the left wrist, right knee, leg and ankle as an outpatient. The reviewer reported that the injured worker injured her left wrist and right knee and has undergone an arthroscopy of both the right knee and left wrist. The operative notes and subsequent orthopedic management with current orthopedic evaluation is not available for review. Additionally she has developed evidence of depression and anxiety scoring severely high on the depression scale and moderately high on the anxiety scale. She has had previous individual psychotherapy but Dr. was not able to provide any details indicating how much prior psychotherapy she has had. Based on the lack of current detailed physical examination and lack of documentation with regard to previous orthopedic Intervention

with regard to the right knee and left wrist anti based on the lack of detailed information regarding the prior individual psychotherapy and Its subsequent failure to resolve her problems, the request for a Chronic Interdisciplinary Pain Management Program the reviewer recommended for denial of preauthorization as medically not necessary or appropriate for this injured worker.

10-8-08 , MD., Request for Reconsideration: Response to Adverse Determination: It is unfortunate that all the indications for the chronic pain management program were not considered at the time of the initial request. The claimant suffered injury of the left wrist and right ankle on xx/xx/xx. She has been treated with medications, physical rehabilitation, and surgery of the left wrist and right knee. She has chronic pain, functional deficits, and a clinical depressive reaction as a result of the compensable injury. She has undergone lower levels of psychological intervention with individual psychotherapy and medication Cymbalta. She does not have the pain and stress management skills necessary to adequately function in the presence of constant pain. She has been unable to bring her depression and manageable levels. Her BDI is 37/63 and her BAI is 25/63. She needs more aggressive intervention to control her depressive reaction. She needs specific pain and stress management training so that she will be more functional while dealing with her pain on a daily basis. She also needs to undergo significant vocational readjustment. Other treatment options have been exhausted. The claimant is an appropriate candidate for a chronic pain program to address the significant psychological component of her injury. She understands that this is the final phase of her treatment and that upon completion of the CPMP, she will undergo evaluation for impairment and transition back to work.

10-13-08 , DC., Utilization Review. Upon reconsideration the recommendation of denial of pre-authorization of Interdisciplinary Chronic Pain Management Program for 20 sessions five days per week, eight hours per day for chronic pain of the left wrist, right knee, leg and ankle as an outpatient is upheld, effective 10/13/08. The reviewer reported that based on review of the submitted documentation from Dr. , which included cover sheet dated 10/10/08, evaluations dated 08/13/08, 08/11/08, 05/27/08. 04/29/08, 01/15/08, and operative reports dated 04/03/08 and 01/18/08 and physician review by Dr. , Physical Medicine and Rehabilitation, TM00040. This xx-year-old sustained a work-related injury on xx/xx/xx to the left wrist, right knee, leg and ankle. She currently is treating for problems with her left twist and right knee. A successful teleconference was held on 10/10/08 with Dr. and Dr. . Dr. did submit additional information from the current treating orthopedic surgeon, Dr. . Dr. in his reports indicates that he is going to try to get approval for Supartz injections for the knee. His diagnosis is osteoarthritis of the knee. This certainly indicates that continuing treatment and a good chance that the injections will provide significant relief of her chronic pain. Also submitted was a report from Dr. , the physician who performed surgery on her right wrist. Surgery included a fusion, a left mid carpal-ulnar fusion and a scaphoidectomy. This will leave her with some restricted motion since essentially one row of carpal bones were fused but she should certainly have good functional range of motion. Dr. in his report also has her on a pain medication and his report does not indicate a specific prognosis in regards to functional return. He did place her in physical

therapy. There is no indication as to what the response to the physical therapy was. According to the medical records from the facility, , the injured worker is having some psychological difficulties in terms of coming to grips with her resultant surgeries and current outcomes. This certainly may require some additional psychotherapy. She has had only six sessions of individual psychotherapy according to Dr. and that may not be sufficient to help her deal with her decreased functionality and pain responses. However, the records do not indicate that she is a candidate for a Multidisciplinary Pain Management program at this time. Therefore, recommendation for denial of preauthorization is upheld.

12-3-08 , MD., Letter to Fellow Doctors: The claimant suffered injury of the left wrist and right knee, leg and ankle on xx/xx/xx. She has been treated with medications, therapy, physical rehabilitation, and surgery of the left wrist and right knee. She has chronic pain, functional deficits and a secondary depressive reaction. She has been treated with individual psychotherapy and anti-depressant medication. She also has depression, nervousness, inability to relax, fear, worry about her future, loss of pleasure, increased appetite, self-dislike, irritability, guilt, punishment, and loss of energy. She does not have adequate pain and stress management skills, and a result she has not been able to bring her anxiety and depression to manageable levels. She needs more aggressive intervention to control her depressive reaction. She needs specific pain and stress management straining so that she will be more functional while dealing with her pain on a daily basis. She also needs to undergo significant vocational readjustment. Other treatment options have been exhausted. We have recommended that the claimant undergo chronic pain management program to address the psychological component of her injury. She understands that this is the final phase of her treatment and that upon completion of the CPMP she will undergo evaluation for impairment and return to work.

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

Medical records reflect that the claimant has continuation of pain despite surgery, medications, and psychotherapy. Chronic Pain Management Program is not going to change the negative outlook for this patient. ODG-TWC reflects that one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of

opioid use; and (9) pre-treatment levels of pain. Based on the medical records provided, a Chronic Pain Program is not indicated based on her previous poor response to treatment.

ODG-TWC, last update 12-03-08 Pain Chapter - Chronic Pain Programs:

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 put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders.
Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):
(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:
(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)
(b) Multidisciplinary pain clinics
(c) Pain clinics
(d) Modality-oriented clinics
(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is

referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.
Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.
Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs.

Criteria for the general use of multidisciplinary pain management programs:
Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:
(1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
(2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
(3) 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;

(4) The patient is not a candidate for further diagnostics, injections or other invasive procedure candidate, surgery or other treatments including therapy that would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided);
(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;
(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;
(7) Negative predictors of success above have been addressed;
(8) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit;
(9) 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 these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures 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;
(10) Total treatment duration should generally not exceed 20 full-day 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 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;
(11) At the conclusion and subsequently, neither re-enrollment in nor 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.
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.
(BlueCross BlueShield, 2004) (Aetna, 2006)

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)