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Notice of Independent Review Decision

DATE OF REVIEW: May 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic pain management program x 10 sessions (97799-CP)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician providing this review is a Psychiatrist. The reviewer is licensed in Medicine in the State of Texas. The reviewer is a member of the American Psychiatric Association. The reviewer has been in active practice for 15 years.

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of chronic pain management program x 10 sessions (97799-CP)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who injured her left arm, left shoulder, and neck after lifting approximately 90 chairs and placing them on top of each other.

On August 13, 2007, the patient underwent a comprehensive behavioral medicine evaluation at Accuhealth performed by, Ph.D. The patient was evaluated to determine whether she would be appropriate for a trial of interdisciplinary chronic pain management program (CPMP). The treatment history was obtained as follows: *The patient was initially treated with conservative care including active and passive modalities and chiropractic therapy without any benefit. Magnetic resonance imaging (MRI) of the left shoulder was negative. Electromyography/nerve conduction velocity (EMG/NCV) study was unremarkable. MRI of the right shoulder revealed evidence of supraspinatus tendinopathy, mild subacromial and subdeltoid bursitis, bicipital bursitis, and mild subacromial space compromise. MRI of the cervical spine revealed mild-to-moderate central spinal canal stenosis at C5-C6, moderate left subarticular lateral recess compromise due to paraspinal broad-based protrusion with thecal sac distortion and root contact at C6-C7, and moderate bilateral neural foraminal stenosis at C5-C6 as well as C6-C7. A diagnostic ultrasound revealed evidence of a bursal tissue response to an enlarged tendon over the left shoulder. Ultrasound of the cervical spine revealed inflammatory reaction at the C3 through C7*

joint margins and early form of degenerative disease of the cervical spine. D.O., diagnosed left shoulder internal derangement and cervical strain. The patient was seen by an orthopedic physician, who did not feel the need for any cervical surgery. She was treated with a series of cervical epidural steroid injections (ESIs) with some relief of symptoms. She underwent six sessions of individual psychotherapy in June and July 2007. She benefited from the sessions as evidenced by acquisition of basic pain management skills such as health relaxation, reduced emotional symptoms as per self-report, decreased level of pain, reduced frequency of negativistic thinking. However, psychological indices remained elevated and her therapist indicated that she was unlikely to make further progress via unimodal treatment and appeared to require interdisciplinary chronic pain management services to make further progress in recovery, including elimination of opioid dependence as well as successful return to work.
The patient was utilizing hydrocodone, Xanax, and Ambien. She was functioning at approximately 30-40% of her pre-injury capacity due to pain and weakness interfering with daily activities. Her psychiatric history was significant for an attempted suicide by an overdose of medication in xxxx. She had also received counseling in 2001 to address emotional distress due to her history of emotional abuse by her mother. On Beck Depression Inventory (BDI) she received a score of 27 and on the Beck Anxiety Inventory (BAI) she received a score of 37 suggestive of moderate range of depressive symptoms and severe range of anxiety symptoms respectively. Her assessment suggested that she was suffering from significant psychological symptoms including fear, avoidance of activity, and preoccupation with persistent, debilitating pain. Given the chronic nature of her problem with pain as well as failure to recover successfully despite multiple interventions, a multidisciplinary CPMP was recommended to maximize her ability to return to work and/or regain an activity lifestyle.

In February 2008, , D.O., prescribed Xanax, Vicoprofen and again requested CPMP.

On February 22, 2008, the request for CPMP was denied with the following rationale: *Documentation reports that the patient has a premorbid psychiatric history which includes a suicide attempt. The request is for 10 sessions of CPMP. Treatment goals and treatment plan are not sufficiently individualized for this patient. Most treatment goals are not objectively stated. The negative predictors for successful completion of CPMP included high level of psychosocial distress, pretreatment level of depression, pain and disability, prevalence of opioid use, and duration of prereferral disability line, which were a poor prognosis for the requested treatment. These factors were reported for this patient, yet these risk factors were not assessed or addressed in the evaluation. A premorbid psychiatric history and previous suicide attempt are reported. The psychological risk factors are not adequately addressed in the patient evaluation and also present a poor prognosis for the requested treatment. The evaluation is over six months old and there has been no attempt to reassess this patient and provide a current evaluation of the patient's symptomatology.*

On March 6, 2008, Dr. again performed a psychological evaluation. The patient scored 28 on the BDI and 44 on the BAI scale suggestive of moderate range of depressive symptoms and severe range of anxiety symptoms respectively. As all conservative interventions had been exhausted, an interdisciplinary CPMP was again recommended. In a physical performance evaluation (PPE), the patient reported increased pain with ROM of the right shoulder and cervical spine. She

was unable to complete some of the tests due to severe pain in her shoulders.

On March 17, 2008, Dr. provided an appeal letter to request reconsideration of the adverse determination for CPMP. He reported that all of the documentation supporting the request had been updated via repeat evaluation and it should be noted that the insurance carrier was responsible for the need for repeat evaluation due to previous inaccurate statements regarding the patient's case being "closed", inaccurate information that had resulted several months delay in providing interdisciplinary CPMP to support a successful and timely return to work. Dr. felt the patient would benefit significantly from participation in an interdisciplinary CPMP to reduce her emotional symptoms and fear as well as avoidance of activity and to achieve the goal of returning to work.

On March 27, 2008, the appeal for CPMP was denied with the following rationale: *Documentation indicates the patient is having "panic-like" symptoms and must take Xanax in order to go to the doctor's office. The patient is taking Vicoprofen and Xanax, reports using alcohol at a moderate level and smokes one pack of cigarettes per day. No additional information regarding alcohol use with narcotic medication and benzodiazepam medication is provided. Dr. indicated during the telephone review of the request that the patient's alcohol use is "not daily use and not overuse" and is likely at the rate of "one or two drinks per day.: Documentation indicates a premorbid psychiatric history with a history of suicide attempt. The appeal request indicates this is a remote history and not thought contributory to the patient's current presentation. There is minimal assessment of psychosocial factors or non-medical obstacles that may be contributing to the maintenance of symptoms in this patient. Dr. indicated during the telephone review of the request that such factors do not appear to be contributing to the clinical job. He indicated that the patient's history of mood disturbances or her family of origin mood disturbances may be contributing to her current affective disturbance. Diagnostic impressions provided include major depression and pain disorder. Severe psychosocial stressors and severe level of pain are also reported in the evaluation. The following variables have been found to be negative predictors of efficacy of treatment with the prognosis 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 level of psychosocial distress (higher pretreatment levels of depression, pain, and disability); (5) involvement in financial disability disputes; (6) greater rate of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; (9) pretreatment level of pain.*

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

The treatment team headed by Dr., PH.D. has successfully answered all of the many objections of the reviewer. Dr. has given evidence of two comprehensive assessments on the claimant that indicate that the claimant's pain and limitations could be improved with a comprehensive pain management program. The reviewer cites 5 ODG criteria which need to be met: 1. An adequate and thorough evaluation has been made, (met) 2. Previous methods of treating the chronic pain have been unsuccessful. (met) 3. The patient has a significant loss of ability to function independently resulting from the chronic pain. (met) 4. The patient is not a candidate where surgery would clearly be warranted. (met) 5. The patient exhibits motivation to change and is willing to forgo secondary gains, including disability payments to effect this change. (met). The reviewer appears to be searching for minute details in order to deny services in this case. For example, the reviewer notes that 20 years prior to the request for services, the claimant had a single suicide attempt. The reviewer also notes that the claimant drinks alcohol "at a moderate level". This was clarified by Dr. to be one or two drinks a day. Neither of these factors is judged to be deterrents to the requested therapy, yet the reviewer uses this as a reason to deny services. In an appeal letter dated March 17, 2008, Dr. states: "The reviewer presents an extremely wide ranging basis for denial, which appears to erect unfair barriers to treatment." After careful review of all the material, I must agree with Dr. assessment.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES