URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WCN

DATE OF REVIEW: 2-19-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 10 sessions

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

Psychologist

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

- MD., office visits on 7-8-08 and 8-19-08.
- 8-20-08 EMG/NCS of the lower extremity.
- 8-26-08 Physical Performance Test.
- Physical therapy from 9-15-08 through 10-15-08, for a total of 10 sessions.
- 11-6-08 Functional Abilities.
- 11-12-08 MEd, LPC., Evaluation.
- 12-5-08 PhD., Utilization Review.
- 12-23-08 LPC., provided an appeal letter.
- 1-12-09 PhD., Adverse determination.

PATIENT CLINICAL HISTORY [SUMMARY]:

7-8-08, MD., the patient is a xx-year-old female employed by xxxx, as a xxxx. On xx/xx/xx, the patient was working she was exiting the building present on the second floor, she slipped, lost her footing and fell approximately 6 to 7 feet onto the ground. She reports loss of consciousness for unknown duration of time. On awakening, she noted pain in her neck, lower back, right shoulder, right hip, right buttocks, and right thigh. Injuries were reported to her employer who referred the patient for treatment at Hospital emergency room. She was evaluated, x-rays were taken, given oral medications, and verbally told that she had a fractured right greater trochanter. She was later evaluated by Clinic and provided a diagnosis of back buttocks contusion, right shoulder strain and pain. She was prescribed oral medications and Biofreeze. She was sent back to work on modified work duty. She was later evaluated by Dr., who obtained x-rays of right shoulder and recommended an orthopedic consultation, which was denied by carrier,. She underwent designated doctor evaluation on May 13, 2008, performed by M.D, who determined the patient was not at MMI. He obtained an x-ray of the patient's right hip, which demonstrated no localizing pathology with no fracture noted. MRI of her right shoulder on June 13, 2008, showing a flail thickness tear of the anterior half of the supraspinatus tendon at its insertion, surrounded by moderate supraspinatus tendinosis, mild tendinosis involving the subscapularis and infraspinatus tendons, AC joint arthrosis, and both mild anterior and lateral acromion downslopping, small glenohumeral joint effusion, and subacromial - subdeltoid bursitis present. At the

end of exam, Dr. recommends orthopedic surgical consultation. The patient is referred by network carrier on this date for continued evaluation and treatment. She presents complaining of neck pain, which she rates as 5 on a scale of 10, described as dull, intermittently sharp radiating into her right shoulder, sharp stinging right shoulder pain radiating into her deltoid and right upper arm, profound right upper arm weakness, pain on motion, with intermittent numbing sensations along the lateral aspect of her upper extremity, upper back pain described as constant and felt as a stiffness or tightness radiating into bilateral scapulae, low back pain described as constant dull intermittently sharp radiating into bilateral hips, right greater than left, and intermittent paresthesias along the posterolateral aspect of her right lower extremity. The patient's low back pain increases on prolong sitting or standing, as well as stooping, bending, lifting, or climbing. Rig t hip, pain is described as sharp and radiating along the lateral aspect of her right thigh to just above her knee. The evaluator recommended orthopedic referral for repair of the right shoulder rotator cuff tear. She is to have 12 additional sessions of physical therapy. She is prescribed a TENS unit with Biofreeze, Medications are Darvocet-N 100 one p.o. t.i.d. #45, Flexeril 10mg one p.o. q.h.s. #15, and Lidoderm 5% patch to apply one to the affected area to the 12-hour period once daily #1 box.

8-19-08, MD., the evaluator reported that as previously stated, the patient is in orthopedic surgical referral to Dr. with exam pending. The claimant possesses significant right parascapular myospastic component, as well as trigger points with severe range of motion deficits. She would like 12 units of physical therapy in order to address presurgical conditioning of her of her right shoulder girdle reducing her scapulohumeral myofascial pain through passive modalities, allowing for improved blood flow, reduced edema, with lymphatic clearance of toxins thus better healing in more appropriate postoperative surgical result. We will obtain PPE to demonstrate her present deficit. She is prescribed Darvocet-N 100 one p.o. t.i.d, #45, Flexeril 10 mg one p.o. q.h.s. #15, and Lidoderm 5% patch apply one to the affected area for 12-hour period once daily #1 box. Follow up in two weeks.

8-20-08 EMG/NCS of the lower extremity shows mild to moderately severe peripheral polyneuropathy.

8-26-08 Physical Performance Test shows the claimant is functioning in a Sedentary PDL.

Physical therapy from 9-15-08 through 10-15-08, for a total of 10 sessions.

11-6-08 Functional Abilities Evaluation notes the claimant was not able to meet the requirements for her job duties. The claimant's job duties are within the Sedentary PDL.

11-12-08 MEd, LPC., The patient reports an on the job injury while working for xxx as a xxxx. The patient relates that she slipped on ice and fell down the stairs at a 6-7 foot drop. She continued to work for xxx weeks after her injury. She had been working for 9 years prior to her injury. She perceives herself to have been a good employee prior to her injury and was satisfied with her job at the time. Her current physical/mental

complaints include fatigued, deep pain, “brings tears to my eyes” - mostly in the right shoulder and right hip. She is not currently working but expressed a desire to return to work stating that she is easily bored and unfulfilled. The claimant has been treated with Diagnostics include X-Ray, MM and EMG. Treatment included physical therapy with increased pain severity, E-Stim, Tens Unit, ultrasound, massage therapy, exercise therapy, stretching, heat/ice, topical analgesics (Biofreeze) and injections. The patient is prescribed Ultram, Flexeril 10 mg (pain medication, spasm medication), Lidoderm Patch 5% and Darvocet-N 100. The patient reports other medication not related to the current injury. The patient reports that she is having interruptions in her sleep habits. She reports waking intermittently and that pain sometimes interrupts her sleep. She states that she gets 4 hours of sleep per night and her quality of sleep is poor. Prior to her injury she reports getting 8 hours of sleep per night. She reports moderate fatigue 75% of the time. The clinician observed the patient’s mood as depressed and her affect sadness and frustrated. The patient reports weight changes (fluctuates 20 lbs). She is drowsy and her thought content includes worthlessness, helplessness and hopelessness. Socially she reports a loss of interest. She has no suicidal or homicidal ideations at the time of the interview. The patient was given a Clinical Interview,. Beck Depression Inventory (36) which indicates severe anxiety, Beck Anxiety Inventory (26) which indicates severe anxiety, Feat Avoidance 24, 37, McGill Pain Questionnaire 31 ;2, Pain Level 7-8, Sleep 4 hours, PCS =32. The patient appeared older than her stated age. Her personal hygiene is poor and she is disheveled. She is cooperative and lethargic. Her speech is slow and slurred. Her mood is moderately depressed and her affect dysphoric, irritable and blunted. She is drowsy and lethargic- Her short term and long-term memory axe within normal limits. Her intellect is average and her flow of thought is normal. She has no hallucinations or delusions. Her insight, judgment and abstraction are good. The patient’s goals are to acquire new skills, (I.e. computers), reduce pain, increase in energy level and feel more productive. These goals are realistic and rational. Diagnosis: Axis I Chronic pain disorder, depressive disorder, anxiety disorder. Axis II no diagnosis, Axis IV: Problems w/primary support group, occupational problems, economic problems. Axis V GAF 49 (Current) Highest Past Year (59) Prior to Injury (65). The assessment results suggest that the patient is experiencing significant distress related to her injury condition and inability to work. Her pain appears to prevent her from performing daily activities. It is recommended that she participate in an Interdisciplinary Chronic Pain Management program in order to reduce subjective pain and improve coping skills to improve her quality of life.

12-5-08, PhD., adverse determination for pain management program 5 x 2 for the right shoulder. The reviewer reported the claimant is possible pending surgery for right rotator cuff according to the designated doctor report from 05/08. The claimant ha had breast cancer, COPD and diabetes. The claimant has not exhausted lower levels of care and is considered a surgical candidate at this time.

12-23-08 LPC., provided an appeal letter regarding the denial for chronic behavioral pain management program. The evaluator noted that this course of treatment is medically indicated for this patient. She has exhausted multiple treatments

unsuccessfully and can benefit from a program that can assist with management of pain while improving her physical functioning and overall status.

1-12-09 , PhD., Adverse determination for requested Chronic Pain Management Program. The evaluator reported that published criteria suggests that referral to a multidisciplinary choric pain program should occur only when completion of all available lower levels of care including all medical and available psychological treatment. In this case, the claimant continues to be a surgical a candidate. She apparently ahs also to completed any lower levels of behavioral chronic pain management care. The Advantage Program is not CARF certified. There is no evidence that it is a high quality program as required.

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

The available information has been reviewed. The claimant has an injury date of, xx/xx/xx. According to the documentation, the claimant may be pending surgery per the Designated Doctor Evaluation from 5/08. There is no available information suggesting that the possible surgery has been completed or is not going to be completed. In addition, the claimant's reported symptoms of psychological distress do not appear to have been addressed or treated. The guidelines state that a Chronic Pain Management Program should only be considered after a patient has exhausted all available lower levels of care and no further medical treatment is being considered. This is not established in this case. Therefore, based on the available information, the request does not appear to be reasonable and necessary for CPMP at this time.

ODG-TWC, last update 02-07-09 Pain – Chronic Pain Program: 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)
Timing of use: Early intervention is recommend (3 to 6 months post-injury) depending on identification of patients that may benefit from early intervention via a multidisciplinary approach. See Chronic pain programs, early intervention. The probability of returning to work for those out over two years may be less than 1%, if such patients are not offered quality, comprehensive interdisciplinary functional restoration programming. In a high-quality cohort study, the short-term disabled group (4-8 months post-injury) achieved statistically higher RTW compared to the long-term disabled group (> 18 months post-injury), suggesting that early use of a functional restoration program is efficacious, but individuals with long-term disability still achieved respectable RTW justifying use of the program. (Jordan, 1998) (Infante-Rivard, 1996) (TDI, 2007)
See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.
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 diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would 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) These programs may be used for both short-term and long-term disabled patients. See above for more information under Timing of use;
(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) See 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 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)