

Becket Systems

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DATE OF REVIEW:

Jun/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5xwk x 2wks; 8 hours per day (97799)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Determination Letters, 3/16/09, 4/9/09
IRO Summary from Carrier, 5/26/09
Employers First Report of Injury or Illness, xx-xx-xx
Goals & Plan, DC 3/9/09
Request for IRO, 5/19/09
Dr., MD (RME) 1/30/09
Dr. MD, 6/25/08
Dr. MD, 6/25/08
Dr. MD, 6/25/08
Dr. 6/25/08
Dr. 6/28/08
Dr. 7/2/08,
Dr. MD, 7/8/08, 9/2/08, 9/17/08, 10/2/08, 10/17/08, 10/31/08,
11/14/08, 12/3/08, 12/17/08, 1/12/09, 2/2/09, 2/16/09, 3/2/09, 3/9/09,
3/23/09, 4/10/09, 4/29/09, 5/13/09
Appeal Letter, Dr. MD, 4/3/09
Team Conference Notes, 11/18/08, 1/6/09
Dr., MD, 8/1/08, 9/15/08
Dr. DC, 8/1/08, 9/15/08
Dr. 9/4/08
Dr. PhD, 9/8/08, 2/25/09
LMSW, 10/20/08
Dr. MD, 10/29/08
CT Scan Head/Brain, 6/25/08
CT Scan Abdomen, 6/25/08

Exam Thoracic Spine, 6/25/08
CT Scan Cervical Spine, 6/25/08
CT Scan Pelvis, 6/25/08
CT Scan Chest/Thorax, 6/25/08
Exam of Lumbosacral spine, 7/8/08
EMG/NCV, 7/29/08, 9/17/08
Ultrasound of Pelvis, 8/1/08
Ultrasound, 8/1/08
MRI of Lumbar Spine, 9/4/08
MRI of Cervical Spine, 9/4/08
Therapy Notes, 7/10/08-2/23/09 (approximately 27 visits)
FCE/PPE 7/9/08, 8/28/08, 10/13/08, 11/21/08, 3/6/09
Trigger Point Injection, 9/4/08

PATIENT CLINICAL HISTORY SUMMARY

This woman was injured at work on xx-xx-xx when she was caught between moving shelves. She complained of pain and was seen at a local ER. She subsequently saw Dr.. The initial visit was on 7/8/08 and the most recent visit was 5/13/09. She had combinations of physical and psychological therapy. There were reportedly 36 physical therapy and another 12 of individual psychological sessions under Dr.. Dr. initially saw her on 9/8/08 and felt she had an adjustment disorder. She continues to complain of left upper and lower extremity pain and weakness with neck and low back pain. The last team note was part of the 5/19/09 appeal.

Her MRI of the cervical and lumbar regions was performed on 9/4/08. These showed disc bulges and protrusion at C3-4, C4-5, C5-6 and L3-4, L4-5 and L5-S1. There was a large right sided disc herniation at L1-2 compromising the right S1 nerve root. There was a right C7 root encroachment by a C6-7 disc. These radiological findings are on the asymptomatic right side. The EMG did not show any evidence of a radiculopathy. Spinal ultrasounds showed synovial swelling of the facet joints.

She had multiple physical examinations by Dr. that showed local cervical and lumbar tenderness, limited motion, but no neurological loss. Her pain drawings varied from local left neck, mid lumbar and medial left thigh pain, to more wide spread pain involving the upper and lower extremities. There were pain management conference notes provided. The team wrote (1/6/09) "...we will consider chronic pain management for her since she does not want surgery...We have nothing more for her at this time...If she gets into chronic pain management, then she will get some additional therapy to help her while in the program."

She underwent a required medical examination by Dr. on 1/3/09. He described his lumbar and lower extremity examination. He found no atrophy or abnormal reflexes. He described "...such limited lumbar AROM in the absence of a lumbar fracture is nonphysiological. ..My medical opinion is that her lumbar ROM was simply self limited.' He then commented on motor strength. "She essentially gave no effort to any resisted left lower extremity motor activities. She had give-way weakness...I could overwhelm all those muscle groups with the strength of my index finger. Clearly this is a nonphysiological presentation and simply demonstrates a lack of effort more so than anything else." Further he wrote "...once again, nonphysiological presentation with 'stocking-type' of sensory deficits."

He turned his attention to the cervical region. He wrote that "she had essentially minimal cervical AROM not bending her neck more than 5 degrees to flexion, extension, left and right lateral bending, and left and right rotation. Even though he had very minimal cervical AROM she only complained of pain with left rotation. Once again, given a lack of any significant cervical pathology, the demonstrated cervical AROM was "simply self-limited." He found normal reflexes and no motor atrophy. He described "nondermatomal left upper extremity sensory changes which did not follow a particular cervical dermatome nor did they follow a particular peripheral nerve distribution." He said that "she had give-way weakness in all major muscle groups of the left upper extremity..." There was no muscle atrophy.

He described superficial abdominal tenderness to the tip of his finger. He concluded that she had “a grossly nonphysiological and an exaggerated presentation and having expansive complaints of subjective complaints of pain (the patient) has no objective evidence of pathology to substantiate her complaints of pain. I find no evidence of clinical pathology reasonably attributable to the occupational event...”

Dr. advised a pain program when he could not offer anything else. The (2/25/09) Behavioral assessment report described her (from BAP-MSQS) “that she perceives high need for additional diagnostic testing to address her difficulties for pain. ...” and that she “does not believe that she has reached maximum medical benefit due to previous medical treatment.” She has depression, anxiety, nervousness and tension. She fears reinjury and has “minimally accepted” ongoing pain and feels she can work through it. He wrote she has kinesiophobia with testing that shows “excessive, irrational, debilitation fear of physical movement and activity resulting from a feeling of vulnerability to painful injury or re-injury”

The appeal letter of 5/19/09 from the treatment team said that although she did not have Post Traumatic Stress Disorder, her behavior was from the injury. She demonstrated fear and avoidance issues. She had exhausted all conservative care. They felt she was motivated. She had severe kinesiophobia.

The records included 3 FCEs. These were on 8/28/08, 11/21/08 and 3/6/09. In all of these, she was unable to lift 6 pounds. Her original FCE showed bilateral weakness. The most recent FCE showed that this lady was “not in any Physical Demand Level.” Dr. advised her to be in a chronic pain program to work on pain management techniques and general conditioning (3/6/09).

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

This patient has been under treatment with the same group of practitioners since 2008 with minimal gains. Records indicate her complaints and restricted movements are nonorganic. There is no evidence of malingering or secondary gain provided. The psychological testing shows there are problems with her accepting or working at her current level. This is reflected in her low PDL level. She did not improve with prior physical therapy and prior psychological therapy. As the requestors noted, they have nothing else to offer her.

While she is reported to be motivated to improve, there is scant evidence of this in the records. A negative factor in the prediction of failure and success is the severity of her pretreatment pain. However, after a review of the records, the reviewer agrees with the treating doctors that there is nothing else to offer her but a comprehensive pain program combining physical and psychological therapy. The ODG allows for treatment when there is deconditioning due to fear avoidance due to pain. The reviewer finds this CPMP is the only treatment option left to her. There are no contraindications to its use. The request meets the ODG criteria for use of pain management programs (see below). The reviewer finds that medical necessity exists for Chronic Pain Management Program 5xwk x 2wks; 8 hours per day (97799).

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 anxiety, 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 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

(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 20 full-day (160 hours) 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 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. 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.

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

ACOEM-AMERICA 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)