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Notice of Independent Review Decision

DATE OF REVIEW: 6/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5xwk x 2wks

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

Certified by the American Board of Anesthesiology with subspecialty certification in Pain Medicine

REVIEW OUTCOME

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

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

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	847.0	97799	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Summary dated 6/7/10

Physician/practitioner notes/evaluations/letters from 9/4/09 through 5/21/10

First report of injury dated 9/4/09

Notice of Disputed Issues(s) dated 10/29/09

Operative report dictated 4/9/10

Medical record for procedure of 1/22/10

X-ray reports dated 9/28/09, 11/12/09, 3/13/10

Physical therapy notes from 9/17/09 through 11/12/09

Official Disability Guidelines provided-Chronic pain programs (functional restoration programs)

PATIENT CLINICAL HISTORY:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was moving a 30 pound battery across a shelf when it slipped off the shelf and landed in her right hand. The patient presented to a clinic with complaints of pain to the right side of her neck and right

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shoulder. The patient was diagnosed with acute cervical strain and acute right shoulder strain. The patient was provided a right arm sling and provided Lortab, Ibuprofen and Soma. The patient underwent a course of physical therapy/chiropractic care x 10 visits. MRI of the cervical spine dated 09/28/09 revealed diffuse cervical spinal stenosis; 7 mm focus of signal abnormality in the C7 vertebral body; minimal posterior central disc protrusion at C6-7 with minimal spondylosis at C4-5; and no intrinsic cord lesion, cord compression or significant neural foraminal stenosis demonstrated.

Interim report dated 10/06/09 indicates that the patient was released to modified duty; however, the patient's employer could not accommodate the restrictions. Interim report dated 10/20/09 indicates that the patient reports neck and right upper extremity are slightly improved. The patient has responded well to therapy, and progress is reported as good.

A peer review was performed on 10/26/09. It was reported that there was no acute structural damage to the cervical spine as causally related to the work event, and the work event resulted in probable soft tissue cervical strain. It was stated that there was no shoulder joint strain. The current treatment plan to include therapeutic activities without manipulation, OTC anti-inflammatory and light duty work was determined to be reasonable.

CT of the cervical spine dated 11/12/09 revealed no fracture or other bony lesions. Interim narrative dated 12/16/09 indicates that the patient has reached a plateau in therapy. The patient underwent epidural steroid injection on 01/22/10 which was not successful. Initial evaluation report dated 01/27/10 indicates that the patient complains of right neck pain, right upper trapezius pain, and right shoulder pain. On physical examination the patient is 5'4" and weighs 230 pounds. Deep tendon reflexes are 1+ right biceps and +2 in left biceps and bilateral brachioradialis. Areas of hypoesthesia were noted within the dermatome areas corresponding to the nerve root levels of C5, C7 on the right. Cervical range of motion is flexion 40, extension 30, bilateral lateral flexion 35 and bilateral rotation 40 degrees. The patient reportedly has an injury to her neck, but according to her scans, not to the degree which would cause the degree of pain in the right side of her neck with spasm and the degree of pain in her right shoulder.

MRI of the right shoulder dated 03/13/10 revealed moderate tendinosis of the distal supraspinatus tendon with no full thickness or partial thickness rotator cuff tear demonstrated. Functional capacity evaluation dated 04/06/10 indicates that the patient's current PDL is less than sedentary to sedentary and required PDL is medium. Behavioral health assessment of April 2010 indicates that the patient reports loss of energy and motivation, restlessness, forgetfulness and weight gain. There is also evidence of excessive sleep, social withdrawal and inactivity. Mood was subdued and depressed and affect was restricted. The validity scales of the MMPI-2 indicate that the clinical profile is somewhat questionable for interpretation. The clinical profile described her as an individual who suppresses distressful emotions and has difficulty processing these emotions. SOPA responses indicate considerable anxiety and fear of re-injury. Diagnoses are pain disorder associated with psychological factors and a general medical condition; and depressive disorder NOS, secondary to her injury and the impact her injury has had on her life. The patient underwent intraarticular and subacromial injection of the right shoulder on 04/15/10.

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The patient was seen in follow up on 05/13/10 and reported no further pain in the shoulder following the injection. The patient underwent diagnostic facet blocks at C5-6 and C6-7 on 04/09/10.

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

In the Reviewer's opinion, based on the clinical information provided, the request for chronic pain management program 5 x wk x 2 wks is not recommended as medically necessary. A peer review performed 10/26/09 noted that there was no acute structural damage to the cervical spine as causally related to the work event, and the work event resulted in probable soft tissue cervical strain. It was noted that there was no shoulder joint strain. Initial evaluation report dated 01/27/10 indicates that the patient has an injury to her neck, but according to her scans, not to the degree which would cause the degree of pain in the right side of her neck with spasm and the degree of pain in her right shoulder. Behavioral health assessment dated April 2010 indicates that the patient's validity scales of the MMPI-2 indicate that the clinical profile is somewhat questionable for interpretation. Given this information, there appears to be significant motivational issues for this patient who presents with subjective complaints which appear to outweigh any objective findings. Additionally, although MMPI testing was questionable, the patient was diagnosed with depressive disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy or been placed on antidepressant medication. Given the current clinical data, the request for chronic pain management program 5 x wk x 2 wks is not indicated as medically necessary for this patient.

Reference:

2010 Official Disability Guidelines, 15th edition, Work Loss Data Institute, online version, Pain Chapter.

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.

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(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 (80 hours) 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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(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.

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. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification

approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; 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)