

DATE OF REVIEW: JUNE 11, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Initial Chronic Pain Management x 80 Hours.

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

The physician reviewing this case is American Board Certified in Anesthesiology with a secondary specialty 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)

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

There is an Employers First Report of Injury or Illness that states the claimant sustained a strain injury while lifting material at work.

On xx/xx/xx, M.D. an orthopedic surgeon, evaluated the claimant. X-rays reviewed showed no evidence of a fracture/dislocation. Impression: She may have subluxed the shoulder and it is possible that she tore her rotator cuff interval. Dr. prescribed Celebrex.

On xx/xx/xx, an MRI of the right shoulder was performed. Impression: Unremarkable MRI of the right shoulder as interpreted by M.D.

On May 9, 2006, the claimant attended a follow up appointment with Dr.. Dr. gave her a subacromial injection with Celestone-lidocaine. Dr. stated she will start physical therapy and change her medication to Mobic.

On June 12, 2006, the claimant attended a follow up appointment with Dr.. He stated that she may have cervical radiculopathy or a pinched nerve in her neck. He prescribed her Ultram as the Talwin upset her stomach.

On August 3, 2006, , M.D, performed an EMG of the upper extremities. Impression: There is no electrodiagnostic evidence of a right cervical radiculopathy, focal entrapment neuropathy or polyneuropathy at the present time.

On September 7, 2006, an MRI of the cervical spine was performed. Impression: Small central posterior disk protrusion at C5-C6 as interpreted by M.D.

On October 19, 2006, the claimant was evaluated by M.D for a Required Medical Examination. Dr. opined that the structural damage is to the right upper extremity. She did not sustain any damage to the neck or shoulder. However, it is possible she sustained a stretch injury to the brachio plexus or one of the other nerves in the upper extremity. He anticipated that she will recover over the next 4 to 6 months.

On October 19, 2006, the claimant participated in a Functional Capacity Evolution. She provided consistent and maximal effort. She is currently at a light PDL.

On October 30, 2006, M.D. a pain management specialist, evaluated the claimant. At the time of the exam she was at a 4 on the VAS pain scale. Impression: Spasticity, subclinical case of plexopathy. Dr. prescribed Nerontin 400mg

On January 8, 2007, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 4 on the VAS pain scale. Dr. increased her Neurontin to 600mg and increase Robaxim to 500mg. He stated she could return to her usual occupation.

On March 13, 2007, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 4 on the VAS pain scale. Dr. added Lyrica to her medications.

On May 1, 2007, Dr. placed the claimant not at MMI and expected her to reach MMI on or about July 31, 2007.

On May 8, 2007, M.D. released the claimant to work full duty without restrictions.

On December 18, 2007, M.D. placed the claimant not at MMI and expected her to reach MMI on or about May 18, 2008.

On January 11, 2008, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 2-4 on the VAS pain scale.

On March 11, 2008, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 2-4 on the VAS pain scale. He decreased her Robaxin and added Zanaflex to her medications.

On February 4, 2009, an EMG/NCV of the upper extremity was performed by M.D. Impression: Normal study.

On February 10, 2009, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 2-5 on the VAS pain scale. Dr. discontinued her Baclofen and Robaxin. He added Flexeril to her medications.

On February 17, 2009, M.D., a neurologist, evaluated the claimant. Impression: Post-traumatic right arm pain with no objective evidence for cervical spine pathology, nerve root pathology, brachial plexus pathology, intrinsic shoulder pathology or peripheral nerve entrapment.

On May 19, 2009, Dr. performed a re-evaluation of the claimant. At the time of the exam she was at a 2-5 on the VAS pain scale. Current medications: Lyrica 200mg and Flexeril 10mg. He added Skelaxin to her medications.

On July 6, 2009, M.D. evaluated the claimant. Impression: thoracic outlet syndrome.

On September 8, 2009, an MRI/Arthrogram of the right shoulder was performed. Impression: Technically successful intra-articular injection of gadolinium with no evidence to suggest full thickness rotator cuff tear or adhesive capsulitis. There is no evidence of rotator cuff or labral pathology. Minimal bursitis as interpreted by, M.D.

On February 18, 2010, the claimant underwent a mental health evaluation performed by Ph.D. He recommended she receive a trial of 10 sessions in an interdisciplinary pain management program, 8 hours a day, 5 days a week, for 2 weeks.

On February 19, 2010, the claimant participated in a Functional Capacity Evaluation. She demonstrated maximal effort. She is able to safely work at a sedentary PDL.

On March 23, 2010, Ph.D. performed an utilization review on the claimant. Rationale for Denial: She has had significant treatment to date including diagnostics, physical therapy, an arthrogram, and medications. There is not a note available when Dr. recommends chronic pain management program or reviews the treatment plan for the claimant. The treatment is not considered reasonable and necessary.

On April 20, 2010, D.O., an Occupational and Environmental Medicine, performed an utilization review on the claimant. Rationale for Denial: She has had significant treatment to date including diagnostics, physical therapy, an arthrogram, and medications. There is not a note available when Dr. recommends chronic pain management program or reviews the treatment plan for the claimant. Dr. reported that surgery is not recommended for the claimant. It is not established that this claimant meets the psychological criteria for CPMP nor is the treatment plan from her treating doctor clear. The treatment is not considered reasonable and necessary.

PATIENT CLINICAL HISTORY:

The claimant is a female who was employed in xxx. She sustained an injury to her right arm when she was putting the last case of detergent up on the pallet when it shifted weight and caused her right arm to become pinned between that box and another pallet.

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

Ph.D. performed a mental health evaluation on February 18, 2010. He recommended a trial of 10 sessions in an interdisciplinary pain management program, 8 hours a day, 5 days a week, for two weeks. That appears to be the first time a formal pain management program has been advised. Dr. documents the following: "Pain causing the significant distress or impairment in social, occupational, and other functioning. The claimant has been unable to return to work. The claimant experiences significant pain and is limited in terms of physical activities, is severely depressed, has severe anxiety, is fatigued, and has marked decrease in the quality and quantity of her social

relationships.” Based on the ODG Guidelines the previous denials are overturned.

<p>GEChronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs:</p> <p><u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(5) If a primary reason for treatment in the program is addressing possible</p>
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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)