

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cont. Chronic Pain Management Program 5xwk x2wks

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

This physician is Board Certified by American Board of Pain Management and Anesthesiology with 40 years of experience.

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 that states the claimant sustained an injury to the shoulder while lifting material.

On September 17, 2008, the claimant participated in a Physical Performance Evaluation. The claimant displayed consistency of effort and was fully cooperative. She is a candidate for active Therapeutic Exercise program.

On December 2, 2008, DC addressed a letter to the Office of Injured Employee Council. He was asked to answer 7 questions. Dr. stated that the claimant reported she sustained an injury to bilateral wrists and shoulders while working as a arranging merchandise on a shoulder level shelf when she went to lift a box of copy paper and noticed discomfort in her shoulders and wrists. She originally complained of bilateral shoulder pain and bilateral wrist pain. She was diagnosed with bilateral shoulder and wrist sprains. The conditions were not pre-existing and were based on subjective and objective findings. Treatment will consist of therapeutic exercise program and MRI of the shoulders and wrists. She does have the ability to work full duty.

On December 7, 2008, an MRI of the right shoulder was performed. Impression: 1. Tendinopathy, partial tear supraspinatus segment rotator cuff without full thickness tear. 2. Intrasubstance tear of the long head of the biceps tendon as interpreted by Dr..

On December 7, 2008, an MRI of the right wrist was performed. Impression: 1. Subchondral irregularity edema involving the proximal medial aspect of the lunate consistent with ulnar abutment. 2. Negative ulnar variance with small tear of the TFCC and minimal effusion of the distal radioulnar joint. 3. Extensor carpi radialis brevis and longus tenosynovitis as interpreted by Dr..

On December 7, 2008, an MRI of the right shoulder was performed. Impression: 1. Tendinopathy, partial tear supraspinatus segment rotator cuff without full thickness tear. 2. Intrasubstance tear of the long head of the biceps tendon as interpreted by Dr..

On December 7, 2008, an MRI of the left shoulder was performed. Impression: 1. Tendinopathy, partial tear of the rotator cuff. 2. SLAP lesion extending into the long head of the biceps tendon. 3. Partial subscapular tendon tear with subluxation of the long head of the biceps tendon out of the upper bicipital groove as interpreted by Dr..

On December 7, 2008, an MRI of the left wrist was performed. Impression: 1. Neutral ulnar variance with ulnar abutment, subchondral edema and slight irregularity proximal medial aspect of the lunate as interpreted by Dr..

On February 2, 2009, M.D., an orthopedic and hand surgeon performed a peer review. He determined that although it appears that some of the claimant's complaints and conditions were treated under workers compensation system, it should be noted that all of the claimant's complaints and conditions involve primarily the Musculoskeletal system and secondarily some peripheral nerves and are compatible with a Disease of Life. It is reasonable to conclude that no compensable diagnosis has been properly validated.

On August 10, 2009, the claimant participated in a physical performance evaluation. The claimant displayed consistency of effort and was fully cooperative. She is a

candidate for Comprehensive Occupational Rehabilitation Program or Work Hardening Program.

On September 15, 2009, M.D., an orthopedic surgeon evaluated the claimant. She has received 20 sessions of physical medicine rehabilitation and is taking Motrin and Tylenol for pain without significant improvement. Dr. injected the right and left shoulders with Depo Medrol with a reported 75% pain relief.

On October 9, 2009, the claimant was re-evaluated by, M.D for a pre-operative evaluation. She is cleared for surgery of the left shoulder.

On October 12, 2009, the claimant underwent surgical intervention of the left shoulder as performed by, M.D. Procedures: 1. Arthroscopic decompression. 2. Mini open rotator cuff repair with long head of biceps tenodesis and Orthobiological graft.

On December 15, 2009, the claimant was evaluated by PhD for chronic pain management. Impression: There is a strong indication that he patient is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety, which is secondary to her work, related injury. She meets the criteria per the ODG's for individual therapy sessions.

On February 1, 2010, the claimant was re-evaluated by, M.D. She states she the left shoulder pain and stiffness has decreased significantly with the completion of physical medicine rehabilitation. She was instructed how to do at home stretching properly.

On February 8, 2010, M.D. placed the claimant at MMI as of the date of exam with a 7% whole person impairment rating based on range of motion deficits.

On February 8, 2010 the claimant participated in a functional capacity evaluation. She is currently able to work in a light PDL.

On March 1, 2010, the claimant was re-evaluated by, M.D. She stated that her range of motion has not improved since the last visit and her pain has become worse. Impression: Severe adhesive capsulitis of the left shoulder. She requires manipulation under anesthesia.

On March 1, 2010, the claimant was re-evaluated by, M.D. for a pre-operative evaluation. She is cleared for surgery of the left shoulder.

On March 18, 2010, the claimant underwent surgical intervention of the left shoulder as performed by, M.D. Procedures: Arthroscopic Debridement and manipulation under anesthesia.

On June 1, 2010, the claimant participated in a Functional Capacity Evaluation. She is able to perform at a Sedentary to Light PDL. She is a good candidate for a Comprehensive Occupational Rehabilitation Program or Work Hardening Program.

On June 22, 2010, the claimant was re-evaluated by, M.D. She has been doing at home exercises and receiving physical medicine and rehabilitation. She is to continue at home exercises.

On July 26, 2010, the claimant participated in a physical performance evaluation. She is able to perform at a Sedentary to Light PDL. She is a good candidate for a behavioral assessment evaluation.

On September 8, 2010, the claimant was re-evaluated by PhD. He requested 10 additional sessions of chronic pain management as she is slowly making progress toward her goals and ability to improve in the daily activities of her life. She originally participated in 10 sessions of chronic pain management. She demonstrates the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce after completing her treatments.

On September 14, 2010, Ph.D performed a utilization review on the claimant. Rationale for Denial: The claimant had recently completed 10 days of chronic pain management program. The claimant reportedly decreased her pain level from 5/10 to 4/10. The claimant improved from sedentary/light physical demand level to medium PDL with a required PDL of heavy. If she has improved, as Dr. stated to a Medium PDL, there is no reason she cannot return to some type of employment or participate in retraining at this time.

On September 30, 2010, , D.O. performed a utilization review on the claimant. Rationale for Denial: Given that she has completed the prior 17 days of work hardening, has made little progress psychologically, and the documentation does not reflect significant improvements in her physical abilities the request is denied.

The claimant was in work conditioning from 8/12/09 to 7/2/10.

There are SOAP notes from 9/16/08 to 8/30/10.

The claimant was in physical therapy from 6/2/09 to 5/17/10.

PATIENT CLINICAL HISTORY:

The claimant is right hand dominant that sustained trauma to both wrist and shoulder during the course and scope of her job on xx/xx/xx. The claimant states she was lifting heavy boxes at work.

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

The claimant had her most recent surgery on the left shoulder on March 18, 2010. Since that time the claimant has had multiple sessions of physical medicine and rehabilitation treatments. In addition she had at least 10 sessions of chronic pain management. The claimant had multiple FCE's and at least 17 days of work hardening programs. Through this treatment she has moved from sedentary/ light physical demand level to medium PDL. At that level the claimant can continue with a home exercise program and return to the workforce and/or participate in a retraining program. Her pain level decreased from a 5/10 to a 4/10; there is no indication that additional chronic pain management program days would be as beneficial as a continuation of the home exercise program and vocational retraining. Therefore, the adverse determination is upheld.

Per ODG Guidelines:

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 (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)