



IRO# 5356
5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100
DATE OF REVIEW: 10/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional 10 sessions of a Chronic Pain Program at 5 days a week for 2 weeks for 80 hours total

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

This case was reviewed by a Texas licensed DC, specializing in Chiropractic. The physician advisor has the following additional qualifications, if applicable:

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Additional 10 sessions of a Chronic Pain Program at 5 days a week for 2 weeks for 80 hours total	97799	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	Dr.	16	09/14/2010	09/14/2010
2	Designated Doctor Report	MD	13	02/22/2010	02/25/2010
3	FCE Report	Healthcare	5	07/29/2010	07/29/2010
4	IRO Request	Healthcare	9	09/09/2010	09/14/2010
5	Peer Review Report	MD	4	03/20/2010	03/20/2010
6	Psych Evaluation	Healthcare	15	07/14/2010	07/14/2010
7	Initial Request	PhD	5	08/17/2010	08/30/2010
8	Initial Denial Letter		10	08/19/2010	09/07/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the submitted data (77 pages) and archived information, the claimant is a male who injured his right arm while at work on XX/XX/XX. The claimant reported that his right arm was caught between the base plate and a compression compactor for approximately 5 minutes. He was transported to Hospital and examined in the emergency department and subsequently admitted for 3 days to observe/avoid compartment syndrome of the right upper extremity. However, compartment syndrome did not occur and he was released and recommended to follow-up with Dr. (orthopedic surgeon). On 09-08-08, the claimant was examined by Dr. and treated for minor abrasions and pain. The claimant was recommended to have physical therapy and other diagnostic testing which did not subsequently occur. The claimant changed treating physicians to Dr. (chiropractic physician). On 09-29-09, Dr. examined the claimant and ordered an MRI of the right forearm. On 10-01-08, an MRI was performed with findings of a healing fracture of the radial head, hematoma and contusions. Dr. began rehabilitation to the upper extremity in December 2008. On 01-23-09, Dr. (orthopedic surgeon) examined the claimant and diagnosed complex regional pain syndrome (CRPS). However, there appears to a lack of medical information about the patient's care from this point. On 01-27-09, the claimant was examined by Dr. (orthopedic surgeon) and no reports regarding this examination from this provider are available. On 09-03-09, the claimant was sent to a designated doctor examination with Dr., but as before, no reports were included from this provider. Dr. (pain management specialist) performed 4 ganglion blocks from February thru September 2009. On 09-28-09, Dr. recommended a spinal cord stimulator. On 10-30-09, the claimant was examined by Dr. (psychologist) who indicated the claimant has significant anxiety and depression. On 01-15-10, Dr. performed ROM and strength studies of the right upper extremity.

On 02-22-10, the claimant was again sent to a designated doctor examination, this time with Dr., who indicated the claimant was not at MMI due to his concern of radiculopathy from the cervical spinal region not being assessed. However, Dr. own examination recorded that the patient's neurological status was normal. On 02-24-10, the claimant again changed doctors from Dr. to Dr. who changed his medications. On 07-14-10, Dr. (psychologist) indicated in his report that the claimant had just completed 10 sessions of chronic pain management program from 06-10-10 thru 07-14-10. On 07-29-10 an FCE was performed which indicated the claimant was at a light PDL. At that time a request for an additional 10 sessions of CPMP which was denied due to a failure of meeting the treatment goals.

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

After reviewing the FCE dated 07-29-10 and the previous records/reports regarding this claimant's condition, it is obvious this claimant's pain and objective findings have not changed throughout the case. It appears that very little of anything has helped this claimant's subjective complaints. The request is for an additional 10 sessions of CPMP. However, the reports do not indicate the claimant is having any forward progress from the initial 10 sessions of the CPMP. The claimant has undergone a plethora of treatment which included physical therapy, injections, pharmaceutical intervention, chiropractic, psychological and now 10 sessions of CPMP, but without any significant improvement in the claimant's condition. The FCE indicated the claimant's lack of strength and ROM are limiting and probably due to the subjective pain and/or the fear and anxiety of reinjury or the pain itself. Therefore, the objective documentation of the study is skewed. The chronic pain management programs are set up to help in these types of scenarios, but there are complications that lead this reviewer to doubt the success of this claimant's progress in this requested program. The clinical guidelines have indicated and stipulated the predictors of success and failure and list "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](#)) " From the submitted data it appears the claimant does not have a job to return to, has financial difficulties due to this injury and has been diagnosed with physical and psychological factors, including depression, anxiety and sleep disorder, based on the evaluation of Dr.. Based on all the information provided, this claimant meets 1-5 and 7-9 of the variables found to be negative predictors of efficacy of treatment with the programs being requested. Furthermore, it does not appear the initial 10 sessions of CPMP were performed in the recommended time frame of no

more than 20 days. As noted by Dr. the claimant began his CPMP on 06-10-10 and completed the 10th session on 07-14-10. This also indicates a possible lack of compliance. Therefore, the request for an additional 10 sessions of chronic pain management program is not supported by the guides, current clinical information, nor is it considered medically necessary or reasonable.

ODG Criteria for the general use of multidisciplinary pain management programs:(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.

(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- 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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 10/04/2010.