

I-Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 80 hrs 97799

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

MD, Board Certified Orthopaedic Surgeon

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

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Pain – Chronic Pain Programs

, 8/5/10, 7/22/10

Electrodiagnostic studies, Dr., 06/27/08

Request, 01/04/10

Medication Record, 05/18/10 – 08/25/10

Computerized ROM testing, 05/13/10

Review, Dr., 10/05/09

Office notes, Dr., 12/17/09, 03/01/10

Letter of medical necessity, 12/18/09

Functional testing, 07/08/10

Requests, Dr., 07/14/10, 07/28/10

Reviews, 07/22/10, 08/05/10

Physical Performance Test, 08/26/10

Note of appeal, Dr., 09/02/10

PATIENT CLINICAL HISTORY SUMMARY

This claimant is and was noted to have sustained herniated discs from an injury. He underwent 2 anterior cervical discectomies and fusions in 2005 with good results, but had a component of residual numbness and weakness affecting the left upper extremity. EMG studies in 09/05 and 01/06 reportedly showed right C7 and bilateral C8 radiculopathy. These reports were not provided. He was noted to have done well until he was injured on xx/xx/xx at which time the left elbow folded back on itself with subsequent left elbow, forearm and hand pain, swelling with numbness and weakness. Initial x-rays were reportedly unremarkable. He reported relief of symptoms with therapy and injections, but was not the same. Reportedly an MRI of the left elbow, date not given showed tendon and ligament damage. On 02/08/08 he underwent left elbow surgery to the olecranon bursa with some relief.

Dr. saw the claimant on 06/27/08 for electrodiagnostic studies. The complaints of persistent left elbow pain intermittently radiating into the left forearm and hand with numbness,

weakness and limited motion, chronic neck stiffness without frank radicular symptoms were noted. The electrodiagnostic studies showed mild, chronic left C8 radiculopathy without ongoing/active denervation and relative sparing of motor units on needle EMG, representing interval improvement/stabilization relative to the study performed 01/09/06. There was no evidence of ulnar mononeuropathy at elbow or other focal upper extremity peripheral neuropathy on the left side. Left upper extremity sensory nerve conduction studies were normal in the presence of clinical hypoesthesia support pathology proximal to the dorsal root ganglia, ie at the root/spinal level and make a post ganglionic lesion such as a plexopathy or peripheral neuropathy less likely. The left upper extremity motor and sensory nerve conduction studies were well within normal limits and showed no significant interval changes relative to the previous studies from 1999, 2005 and 2006.

Dr. reviewed the case on 10/05/09 and did not recommend the use of Tramadol, Piroxicam, Hydrocodone, Zolpidem or Carisoprodol. He felt the claimant was at maximum medical improvement without objective functional deficits.

Dr. saw the claimant on 12/17/09 for persistent elbow pain and occasional numbness/tingling in the first 2 digits of the left hand. The claimant said about a week prior he woke up and had severe numbness in the entire left upper extremity that lasted for a few hours. The examination showed tenderness of the anterolateral aspect, good motion with mild to moderate pain, and weakened grip strength on the left. Chronic elbow and left wrist pain were diagnosed. Dr. did not anticipate any other treatment other than maintenance of medications. At the 03/01/10 followup left elbow pain with popping sensation and occasional numbness/tingling in the first 2 digits of the left hand were noted. There was continued tenderness at the anterolateral aspect, good motion with mild to moderate pain and a weak grip strength on the left. X-rays of the left elbow that day showed no bony abnormalities, fractures or subluxations. A mental health evaluation on 07/06/10 indicated that the claimant was an appropriate candidate for a comprehensive chronic pain management program and recommended 80 hours.

Functional testing on 07/08/10 noted that the claimant's job fell within the heavy level of demand and that he was currently performing at a light to medium level. He passed the validity criteria. On 07/14/10 Dr. requested a chronic pain management program to address the psychological aspect of his injury. Reviews on 07/22/10 and 08/05/10 denied 80 hours of a chronic pain management program. A physical performance test on 08/26/10 noted a forward head, protracted shoulders, posterior pelvic tilt and decreased lumbar lordosis. There was tenderness to palpation over the left olecranon, sensation was intact to light touch except the area surrounding the incision site thru the left ring and little fingers. Grip was decreased on the left. Left upper extremity strength was 4/5 throughout. Left elbow motion was: flexion 125 degrees, extension 0 degrees and supination and pronation 80 degrees. All tests were valid and consistent. Treatment 8 hours/day for 10 days was recommended. Dr. authored a letter of appeal on 09/02/10 stating that the claimant was not provided with any form of therapy to wean or detox him off narcotic meds and reported he was taking nearly 12-14 Hydrocodone/day. The claimant's complaints included pain in the left elbow, overutilization of narcotic meds, depressed/sad mood and poor sleep. The claimant was noted to have had several months of therapy, epidural steroid injections and medications, but had ongoing pain which he felt due to his medications and requested assistance to step down off them. He was taking Tramadol, Piroxicam, Hydrocodone, Zolpidem and Carisoprodol. The examination showed a forward head, protracted shoulders, posterior pelvic tilt, decreased lumbar lordosis, tenderness over the olecranon and intact sensation except for the area surrounding the surgical incision thru the left ring and little finger. Upper extremity strength on the left was 4/5. Waddell testing was negative. Dr. stated the claimant was a good candidate for a functional restoration/detox program.

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

The request for a multidisciplinary pain management program would appear to be supported in this particular record based on the totality of the information provided. This individual

appears to have chronic pain with evidence of loss of function. He has reported evidence of deconditioning and has some degree of psychosocial sequela as result of the injury. Furthermore there is evidence of continued use of prescription medications without evidence of improvement, some of which may be resulting in dependency.

The records also document that other attempts to manage chronic pain have been attempted. It does not appear as though there is any evidence to suggest that further surgery is warranted and although substance abuse appears to be an issue in this case is not the entire thrust of the program as outlined. Although records did suggest that there may be some evidence of inconsistency and/or sub maximal effort on testing, more recent physical performance test from August 2010 suggests that the effort was consistent and valid. Furthermore a more recent mental health evaluation and other examiners have suggested that this would also appear to be a reasonable and appropriate next step.

Lastly the request is for 80 hours which represents ten days which is the typical first stage of a program of this nature following which a reassessment would be indicated for its continuation to occur. After considering all of the above information and in consideration, of the evidence based ODG Guides it is the reviewer's opinion that the request for Chronic Pain Management Program x 80 hrs 97799 is medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Pain – Chronic Pain Programs

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.

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)