

## Notice of Independent Review Decision

**DATE OF REVIEW:** DECEMBER 22, 2010

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic Pain Management 5xWk x 2Wks

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

This physician is a Board Certified Physical Medicine and Rehabilitation Physician with 14 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**

On December 10, 2009, an MRI of the right shoulder was performed.  
Impression: 1. Supraspinatus and infraspinatus tendinosis. 2. Probable

infraspinatus tendon delamination with intra-myotendinous cyst formation: no evidence of full thickness rotator cuff tendon tear. 3. Mild to moderate acromioclavicular joint osteoarthritis as interpreted by M.D.

On January 19, 2010, the claimant underwent surgical intervention of the right shoulder was performed by M.D. Procedures: 1. Manipulation under anesthesia, right shoulder. 2. Intra-articular cortisone injection, right shoulder.

On February 26, 2010, the claimant was evaluated by M.D. He will start formal therapy next week. Passive has near full range of motion. He was prescribed Naprelan 750 mg.

On March 31, 2010, the claimant was re-evaluated by M.D. He states his shoulder continues to hurt regardless of physical therapy. Positive impingement sign.

On April 12, 2010, the claimant underwent a behavioral medicine consultation as performed by Ph.D. The work accident pain and ensuing functional limitations have caused this patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. He would benefit from low level of individual psychotherapy for a minimum of 4 weeks.

On June 11, 2010, the claimant underwent an individual psychotherapy treatment re-assessment with M.A. He completed 4 sessions of Individual Psychotherapy with benefit. He noted he feels better overall as a result of having begun to change his thinking. He requires further professional intervention for amelioration purposes in the form of an interdisciplinary pain rehabilitation program.

On July 12, 2010, the claimant was re-evaluated by M.D. He is having a hard time making progress due to shoulder pain. He was prescribed Lodine 400 mg.

On July 27, 2010, the claimant underwent psychological testing with Ph.D. Although passive and active physical therapy, individual psychotherapy and conventional medicine treatment the multiplicity of symptoms persist and he feels hopeless and devoid of skills to move forward in life. He is a good candidate for a Chronic Pain Program.

On August 3, 2010, the claimant participated in a physical performance evaluation. He was able to safely lift and carry 30 pounds. He is not able to meet his previous job demands of a Heavy PDL. He would benefit from a chronic pain program

On August 17, 2010, the claimant attended an interdisciplinary chronic pain program. His pain his rated a 7 out of 10. Treatment plan: Support patient's successful efforts to reduce pain and distress; enhance physical capabilities and

functional abilities; increase engagement in daily and other activities; decrease anxiety and improve sleep.

On September 7, 2010, the claimant attended day 4 of 10 of an interdisciplinary chronic pain program. He rated his pain 8 out of 10. He reported feeling very encouraged emotionally, physically and vocationally as result of his participation in the program but still apprehensive about being able to earn income.

On September 9, 2010, the claimant participated in a physical performance evaluation. He is able to safely lift and carry 50 pounds. He is still unable to perform at a heavy PDL.

On September 14, 2010, the claimant attended day 9 of 10 of an interdisciplinary chronic pain program. His pain is 7 out of 10.

On September 15, 2010, 10 additional days of chronic pain management were requested as they appear reasonable and necessary for any lasting management for his pain symptoms and related psychosocial problems, as it is the recommended treatment of choice for patients with chronic pain.

On September 28, 2010, the claimant attended day 12 of 20 (10 additional days were approved) of an interdisciplinary chronic pain program. His pain is 8 out of 10.

On October 15, 2010, the claimant participated in a physical performance evaluation. He has increased his weight handling ability by 10 pounds to 60 pounds but unable to meet the heavy PDL.

On October 19, 2010, an additional 10 days of chronic pain management were requested.

On October 25, 2010, M.D., a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rational for Denial: The patient with chronic left shoulder pain since injury on xx/xx/xx has completed 20 sessions of Chronic Pain Management program. The medical report dated 10/19/10 indicates the patient has reduced his pain levels from 9/10 down to 7/10. His previous Beck Depression Inventory II score of 29 which falls on the severe range has decreased to 22 which are in the moderate depression level. He has also increased his sleeping hours and has lessened periods of awakenings. He has increased his physical demand level to the medium-heavy, where his job requires Heavy physical demand level. The number of visits exceeds to recommendations set forth by guidelines. Therefore, it is not certified.

On December 2, 2010, Ph.D., a psychologist, performed a utilization review on the claimant Rational for Denial: Documentation indicates the patient completed

20 recent sessions of a chronic pain management program. Documentation indicates the patient had increased physical demand level with prior treatment. ODG states duration of treatment should not exceed 20 full day sessions. Therefore, it is not certified.

### **PATIENT CLINICAL HISTORY:**

On xx/xx/xx , this male sustained an injury to the head, right shoulder, arm, chest wall and right leg while traveling in a pickup truck and sitting in the passenger side when another pick up truck traveling at a high speed came and hit them on his side.

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

The previous decisions are overturned. After 2 years post injury and 20 days of chronic pain management, submitted clinical information demonstrates compliance and progress with increasing function, but short of Heavy job demands. The claimant demonstrated progress in regards to psychosocial stressors as noted by improvement in psychometric scales. Per ODG Pain Chapter under multidisciplinary pain program #12 indicates that total treatment should generally not exceed 20 days (160 hrs) and treatment in excess of 160 hrs requires clear rationale for extension and reasonable goals. There is a clear physical goal to attain Heavy job demands with lessening pain levels and depression with 10 more days of chronic pain management. Therefore, based on the above-mentioned the previous decisions are overturned.

### **Per the 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 pre-injury 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)**