



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: March 17, 2011

IRO Case #:

Description of the services in dispute:

Services denied: Chronic Pain Management x10, Left Shoulder

A description of the qualifications for each physician or other health care provider who reviewed the decision

The clinician who provided this review is a licensed Psychologist in two states. This reviewer is a diplomate in Clinical Neuropsychology, by the American Board of Professional Neuropsychology. This reviewer is a member of the American Psychological Association, the American Pain Society and the National Academy of Neuropsychology. The reviewer has served as the Chief of Neuropsychology and Rehabilitation Psychology at a university medical center, an assistant professor of Psychology, Director of a Children's Rehabilitation Program and staff Psychologist. The reviewer is currently in private practice where has nearly 30 years of experience.

Review Outcome

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

Overtured.

Chronic pain management program for 10 visits is medically necessary.

Information provided to the IRO for review

Records Received:

Request for IRO, 2/28/11, 5 pages

Letter of Denial, 2/25/11, 3 pages

Letter of Denial, 1/25/11, 3 pages

Records Received from URA:

Notice to Utilization of Assignment, 2/28/11, 1 page

Functional Capacity Evaluation (FCE), 1/20/11, 17 pages

Written Request for Chronic Pain Management Program, 12/2/10, 4 pages

Records Received from Provider:

Letter, 3/3/11, 1 page

Notice of Assignment of IRO, 2/28/11, 1 page

Preauthorization Request, 1 page

Reconsideration of Request, 2/18/11, 7 pages

Assessment/Evaluation for Chronic Pain Management Program (CPMP), 1/24/11, 2 pages

Request for 10 additional days of CPMP, 1/24/11, 7 pages

Follow-up Note –MD, 1/20/11, 1 page

Plan and Goals of Treatment, 12/21/10, 5 pages

History and Physical, 12/2/10, 2 pages

Upper Nerve Conduction Report, 11/17/10, 2 pages

EMG Report, 11/17/10, 2 pages

Functional Capacity Evaluation, 10/27/11, 13 pages

MRI Report, 10/26/10, 2 pages

Office Visit, 10/4/10, 3 pages

Initial Behavioral Medicine Consultation, 7/28/10, 5 pages

Operative Report, 3/23/10, 2 pages

Radiology Report, 3/4/09, 2 pages

Patient clinical history [summary]

Medical documentation submitted for review suggested that the claimant sustained an injury to his left shoulder while working. The mechanism of injury was noted to be a slip and fall when he stepped on some water and slipped on the floor and fell backwards injuring his left shoulder and low back. His low back was deemed not compensable. It was noted that he had a labral tear, possible rotator cuff tear, and a superior labral anterior–posterior (SLAP) lesion of his left shoulder with adhesive capsulitis. Due to refractory pain, the claimant was evaluated by this multidisciplinary CARF–certified program and recommended for 10 days in a trial chronic pain management program (CPMP) program. He has completed the 10 day trial with slight self–reported decreases in pain, reports of reductions in muscle tension/spasm, and has reported increased frustration, the same level of anxiety, and increases in depression.

The first reviewer opined that insufficient progress was documented in the first 10 days of CPMP treatment and recommended that additional treatment be denied. In particular, the first reviewer opined that the program had completed insufficient narcotic tapering. As a result of these conclusions, the first reviewer denied additional CPMP treatment.

The program submitted documentation to address deficiencies outlined in the first review by Dr. in their reconsideration request. The program documented that the deficiency outlined by Dr. had

been resolved and a medication titration program (for Tramadol) was available and would be implemented during the second 10 days of CPMP treatment.

The reconsideration was reviewed by a second reviewer (Dr.), who opined that additional CPMP treatment was not medically necessary for a number of reasons. His opinion included the statement that there is no “report/documentation of objective, clinically meaningful improvement in physical output parameters, functional status, pain behavior, or social functioning with the treatment provided.” He apparently disagreed with the concept that an FCE could be provided to suggest functional improvement in physical functioning, disagreed with the use of pain scales, and disagreed with self-reports of clinical improvement provided by the patient and forwarded by the program as evidence of functional improvement in psychological functioning. As a result, he opined that the submitted clinical documentation provided insufficient evidence of appropriate progress in the CPMP program.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The denial for 10 additional sessions of CPMP treatment should be overturned.

After reviewing the submitted documentation, clinical evidence provided by the program, and utilization review reports, it is the opinion that the denial for 10 additional days in a CPMP program should be overturned. Treatment in a CPMP program for chronic pain may result in functional improvement and reductions in pain during the first 10 days of treatment but just as often results in increases in pain and deterioration in psychological functioning as a result of increased stress associated with significant changes in increasing physical activity as well as the psychological stress associated with discussing pain and absorbing the lessons taught in the pain management classes. In addition, the patient is encouraged to focus on a resumption of normal activities which almost always results in increased depression, frustration, and stress. A simplistic model which focuses on determining whether additional CPMP treatment is clinically necessary based on establishing if improvements in physical performance measures or self-reports of psychosocial functioning is inappropriate. In many cases, CPMP patients actually regress during the first 10 days of treatment which is documented in the ODG chapter associate with CPMP treatment. ODG states, “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.”

It is well known by individuals who provide CPMP treatment that patients may improve or

deteriorate during the first 10 days of treatment physically and psychologically. For most professionals who provide pain management treatment, a more appropriate yardstick for deciding how to assess if a patient should continue CPMP treatment includes assessment of motivation and “buy-in” by the patient to determine if they have accepted and are motivated to continue treatment and reduce their reliance on the workers compensation system. As a result of these factors, the determination that 10 additional sessions in the CPMP program should be approved following the initial trial of CPMP care.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines in Workers' Compensation, Online Edition

Chapter: Pain

Chronic pain programs (functional restoration programs)

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) See Biopsychosocial model of chronic pain.

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) (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 – 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. 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.

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