



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 8-31-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program X 10 sessions (5 x week x 2 weeks)

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-7-08 MRI of the right shoulder with IV contrast shows no definite evidence of internal derangement in the right shoulder.

11-20-08 EMG/NCS performed by DC. was normal.

2-19-09 Cardio Duplex of the upper arteries showed no evidence of hemodynamically significant stenosis in the right upper extremity.

7-27-10 MRI of the cervical spine shows loss of the normal lordosis which might be related to the claimant's positioning and/or spasms. Disc protrusion at C4-C5.

2-1-11 Surgery performed by Dr. Right first rib resection. Postop diagnosis: Right thoracic outlet compression.

3-9-11 MD., the claimant is 5 weeks post op from a right first rib resection noting improved pain in the shoulder and arm. She is attending therapy and notes improvement in ROM. She is having dizziness in the morning and evening and thinks it was because of the pain medication. She has discontinued the pain medication for 1 week but still has dizziness. The exam notes normal sensation and early grip. Her shoulder motion is improving. Her scar is moderately sensitive. Will continue formal therapy for nerve glides and strengthening. Scar massage advised.

5-12-11 Functional Capacity Evaluation shows the claimant is functioning at a Light-Medium PDL. Her job requires a Heavy PDL.

6-2-11 Initial Mental Health Evaluation performed by MA, LPC., notes the claimant is being recommended for 6 individual counseling sessions to address her pain syndrome and help reduce the associated symptoms of depression and anxiety and help increase her coping skills. On mental status exam, the claimant appeared alert and oriented to person, place and time. She presents with a flat, tearful, affect and admits to depressed mood over her persistent pain. She has difficulty sleeping at night which exacerbates her anxiety, She has poor concentration, low energy and a loss of interest in most activities. She admits to feelings of isolations frustration and helplessness with crying spells daily. She feels she has lost functionality and ability to perform simple tasks. Voice and rate of speech are low. She denies being suicidal, She denies auditory and visual hallucinations. There is no evidence of a gross thought disorder or substance abuse disorder. Her memory appeared intact. Intelligence was calculated as average.

6-8-11 MD., performed a Utilization Review. He denied the request for individual psychotherapy x 6 sessions.

7-8-11 MD., the claimant is provided with Flector patches and Lyrica. The claimant is to continue with individual counseling/CPMP.

Individual counseling on 6-29-11, 7-5-11, 7-8-11, 7-11-11, 7-15-11, 7-18-11.

7-18-11 Mental Health Evaluation performed by MA, LPC., notes the claimant is a Hispanic female who presents for follow-up evaluation. She completed 6 individual counseling sessions on July 18, 2011, which she says helped her significantly to better cope with her injury and associated depressed/anxious mood. She continues to complain of chronic pain to the cervical, spine, tight shoulder, and right rib area, The daily crying spells have decreased to 1 x weekly, she is less irritable and sleeping better 6 hours with a significant decrease in anxiety. Her concentration has improved and she is more focused on returning to work. She admits to depressed mood over issues of loss of functionality and inability to perform normal tasks she could easily do prior to her

injury. She is not as isolated and is trying to reestablish contact with family and friends. She sustained a work related on xx/xx/xx. She states that she was working as a laborer refilling paper into the machines. A box filled with paper weighting 75 pounds fell on her right shoulder. She sustained an injury to the cervical spine area, right shoulder and dislocated a rib. She underwent a pre-opt ESI injection to the cervical spine 2010, and then a right rib resection and then a post opt ESI injection to the cervical spine without any relief She had physical therapy also without any pain relief. She presents today with a brighter affect, however becomes tearful when describing her continued chronic neck and shoulder pain of 6/10. The claimant is being recommended for 10 Chronic pain management sessions to address her pain syndrome and help reduce the associated symptoms of depression and anxiety and help increase her coping skills. Mental status exam: The patient appeared alert and oriented to person, place and time She presents with a. brighter affect and congruent mood. She admits to depressed mood over her persistent pain, however says she is coping better. She is sleeping better at night with a significant decrease in anxiety. Her concentration has improved and she is more focused on returning to work. Her daily crying spells have decreased to 1x weekly. She feels she has lost functionality and ability to perform simple tasks. Voice and rate of speech are within normal limits. She denies being suicidal. She denies auditory and visual hallucinations. There is no evidence of a gross thought disorder or substance abuse disorder. Her memory appeared intact Intelligence was calculated as average. Diagnosis: Axis I: Pain disorder associated with both a psychological and a general medical condition. Axis II: No Diagnosis. Axis III: S/P Right rib resection, cervical spine and right shoulder injury. Axis IV: Moderate. Axis V: GAF 55. Prognosis: Good. It is strongly recommended that this patient be admitted to an interdisciplinary Chronic Pain Management program, pending insurance approval; for 2 weeks, 5 days a week, 8 hours a. day. The patient's life has clearly been disrupted in many respects as a result of his injury and Pain Syndrome.

7-22-11 MD., performed a Utilization Review. He did not recommend the request for Chronic Pain Management Program for 5 sessions per week for 2 weeks to be reasonable or medically necessary: injured worker is s/p extensive work hardening in the past as well as recent psychological counseling with no objective analysis of measured functional gains. In addition there is no report that baseline level treatment with post PT home exercise program and independent behavioral pain management techniques have been implemented. There is no post individualized psychotherapy testing to support ongoing behavioral /psychiatric abnormalities that are worse than prior to past work hardening treatment. Therefore the requested Pain Management program 5 sessions per week for 2 weeks is not medically indicated.

8-4-11 Appeal Letter provided by MA, LPC., notes the claimant was referred for 10 Chronic pain management sessions to address her pain syndrome and associated symptoms of depressed/anxious mood. She was denied.

The rationale for denial by the reviewer are: 1. "Injured worker is s/p extensive work hardening in the past as well as recent psychological counseling with no objective analysis of measured functional gains". Response: This patient is not s/p extensive work hardening in the past. She has not had any work hardening treatment for this injury. The patient had BDI-H scores 06/02/11 of 50/63 Severe level and BAI scores 06/02/11 of 42/63 Severe level and subsequent scores 07/18/11 of 37/63 and BAT scores of 32/63 indicating a significant decrease in psychiatric distress and definite

functional gains. The BDI-H and BAI are validated psychometric instruments acceptable under ODG guidelines. These results were sent to the peer reviewer but were ignored.

2. "There is no report that baseline level treatment with post PT HEP and independent, behavioral pain management techniques have been implemented" Response: None are required under ODG guidelines as a prerequisite for multidisciplinary pain treatment as this is what is provided in the CPMP.

3. "There is no post individualized psychotherapy testing to support ongoing behavioral / psychiatric abnormalities that are worse than prior to past work hardening treatment" Response: This patient did not undergo any work hardening treatment as was indicated above, therefore this issue is moot. Given the current clinical data submitted this patient is clearly an "appropriately identified patient" and a request for 10 chronic pain management sessions is certainly medically necessary and reconsideration is therefore requested once again for 10 Chronic pain management sessions to address this patient's pain syndrome and associated psychological factors.

8-5-11 MD., the claimant is to continue with current treatment: Flector patch, Lyrica and Tramadol.

8-15-11 MD., performed a Utilization Review. The documentation submitted for review elaborates the patient complaining of ongoing right shoulder pain with associated psychological symptomology. Evidence-based ODG guidelines recommend a chronic pain management program provided the patient meets specific criteria, to include a loss of function, there is documentation of an exhaustion of all other methods of treatment, the patient has not previously been involved in a multi-disciplinary program. The documentation detailed the patient having previously completed 20 sessions of a work hardening program. Upon completion of a multi-disciplinary rehabilitation program, neither re-enrollment nor repetition in a same or similar rehabilitation program is medically warranted for the same condition or injury. Given the excessive nature, this request does not meet guideline recommendations. As such, the documentation submitted for this review does not support this request at this time.

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

EVIDENCE-BASED ODG GUIDELINES RECOMMEND A CHRONIC PAIN MANAGEMENT PROGRAM PROVIDED THE PATIENT MEETS SPECIFIC CRITERIA, TO INCLUDE A LOSS OF FUNCTION, AND THERE IS AN EXHAUSTION OF ALL OTHER METHODS OF TREATMENT. AS PER OBJECTIVE TESTING, MRI AND EMG WERE NORMAL IN THE PAST AND THIS PATIENT DOES NOT MEET THE REQUIRED CRITERIA. THEREFORE, THE REQUEST FOR CHRONIC PAIN MANAGEMENT PROGRAM X 10 SESSIONS (5 X WEEK X 2 WEEKS) IS NOT REASONABLE OR MEDICALLY INDICATED.

ODG-TWC, last update 8-23-11 Occupational Disorders of the Pain – Chronic Pain Management Program: 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).

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)