



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**CLAIMS EVAL REVIEWER REPORT - WC**

**DATE OF REVIEW: 9-8-11**

**IRO CASE #:**

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

Chronic Pain Management x 80 hours CPT 97799

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

Psychologist

**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]:**

xx/xx/xxxx ER visit - the claimant male that presents with complaints of left head and neck pain. The claimant reports slipped on ice. Symptoms are worsening. The claimant also reports intermittent numbness to bilateral hands and fingers. The claimant slipped and fell from ground level. The location where the incident occurred was in the street.

Location: Head neck. The character of symptoms is pain. The degree at present is moderate. CT of the head showed no acute intracranial pathology identified. Old lacunar infarct left basal ganglia. CT of the cervical spine showed no acute displaced fracture is seen. Straightening of the cervical lordosis which may be due to muscle spasm versus patient position. Intervertebral disc bulge at C2-C3 level. Degenerative osseous changes as described. Intervertebral disc space narrowing at C5-C6 level. Impression: Fall, cervical spine strain with active spasm, occipital contusion. Discharged with Lortab, Motrin 800 mg and Robaxin. The claimant was advised to ice for the next 48 hours.

4-13-11 DC., performed a Functional Capacity Evaluation. He notes the claimant has a job PDL of Medium and he is current at a Light Medium PDL. He notes that Per LPC, Mr. scored the following on the Rehab Symptoms Questionnaire: severe perception of disability, severe depression, severe anxiety, severe irritability/interpersonal problems, minimal substance abuse/misuse and severe pain symptoms. Mr. further states that there is sufficient probability of significant psychosocial stress related to the work-related injury to warrant a behavioral medicine evaluation. He notes the recommendation for the claimant to attend a work hardening/work conditioning program according to ODG Treatment Guidelines to continue to improve range of motion, muscle strength/endurance and decrease pain with lifting and/or other work activities so he may return to work as safely as soon as possible.

4-19-11 MD., the claimant is a male. He is here for a new patient appointment as a referral from Dr. Medications were reviewed and updated. He presents with neck pain and a current VAS score of 7. Patient to be evaluated for cervicalgia. The location of discomfort is posterior. It radiates to the left shoulder, left arm, left forearm, hand(s) left, and fourth and fifth fingers. The pain is characterized as constant to sharp to stabbing to throbbing. Initial onset was xx/xx/xx. The precipitating event seems to have been a fall and slipped on ice. Occipital area and lower cervical spine landed on ground.. Associated symptoms include crepitus, headache, neck stiffness and paresthesia in the left hand including the fourth, fifth digit(s). Patient states he get headache everyday starts in back of head and radiates to front forehead on left side. He currently takes the following narcotic pain medication(s): Lortab 5mg 2/day pm (given by Dr. in ER) He reports the following adverse effects associated with use of this medication: somnolence, and he reports that this side effect is very bothersome; In regards to activities of daily living, he reports that his pain does affect this aspect of his life, but he states that medications are helpful in regaining normal ADLs. Chart review shows no aberrant drug behavior. He denies any problems with complying with medication regimen. Patient states he has a hard time looking down and turning neck. He sleeps 3-4 hours in fetal position. Pain does awaken him at night. Patient has tried physical therapy with some relief, chiropractor with some relief. He has not tried TEN's unit. Patient has not worked since xx/xx/xx. Patient is right handed. On exam, neck normal extension with reproduction of pain and decreased lateral rotation with reproduction of pain. There is tenderness left occipital ridge. He is tender left C2-5 facets with paracervical spasm. Sensory is decreased at left C6 and mildly decreased left C7. Motor: biceps, triceps and deltoids intact. CT: Cervical 2/7/11: No acute displaced fracture is seen. Straightening of the cervical lordosis which may be due to muscle spasm versus patient position. Intervertebral disc bulge at C2-3 level. Degenerative osseous changes. Intervertebral disc space narrowing at C5-6 level. Assessment: Cervical radiculitis, cervicalgia with traumatic facet neuralgia, cervical disc degeneration with NF narrowing, tobacco abuse. Plan: He is having some paresthesia will start pt on

Neurontin 100mg 1 @ lunch 3 supper. Will D/C ibuprofen and will start him on Mobic 15mg 1 q day. He will have him continue his Lortab for severe pain but give Ultram 1 q 4-6 for mild pain. (To use with Tylenol). Discussed transforaminal epidurogram and TF epidural steroid injection with patient. He may require left C6 TF should medication changes not help. Medications: He prescribed Mobic 15mg 1 q day, Ultram 1 q 4-6 pm (to use w/ Tylenol), and Skelaxin 800mg 1/2-1 tid pm spasm #90. At this point, will discontinue ibuprofen and Robaxin.

5-24-11 Mental Health and Behavior Assessment - MC, LPC. Diagnosis: AXIS I: Adjustment disorder with mixed anxiety and depression, pain disorder associated with both psychological factors and general medical condition. AXIS II: V71.09 No diagnosis. AXIS III: Chronic Pain. AXIS IV: Ongoing pain and changes to a normal active lifestyle. Economic problems (Loss of income), problems relate to the social environment (socially isolated). AXIS V: GAF = 57, currently. Recommendations: Due to the nature of the claimant's psychological, physical and psychosocial symptoms he is an appropriate candidate and would benefit from treatment in an interdisciplinary CPMP at this point in his recovery. This would allow him to learn more effective pain control methods, set realistic goals about recovery, develop and execute a plan to change careers if necessary and help him learn to resume physical functioning so that he could again participate in previously pleasurable activities. His compliance with lower levels of care indicates that he would be compliant with the program requirements and treatment interventions. He also expresses a desire and willingness to participate. It is therefore, recommended that he be authorized CPMP 80 hours.

8-3-11 Utilization Review performed by PhD., notes this is a male who on xx/xx/xxxx suffered a work related back injury, The injury was noted when the patient fell while at work He has been treated with conservative care and medications only. Current medications are Meloxicam, Tramadol and Metaxalone. The psychological evaluation on 5/24/11 indicated that the patient was experiencing mild depressive symptoms and moderate symptoms of anxiety. Diagnostic impressions included Pain Disorder and Adjustment Disorder, The request is for 10 sessions of a chronic pain management program. There is no current physical exam provided with this request. A Peer Review of records on 5/3/11 concluded that "There are no lesions from the work injury identified in these records that would need surgical correction. Work conditioning-Work Hardening: "There is no need for these programs in this case per ODG criteria. Chronic Pain Management Program/Functional Restoration Program: There is no need for such programs as it pertains to the work injury, per ODG criteria".

8-12-11 PhD., provided a letter of appeal. There was an FCE provided with the preauthorization packet by Dr. which clearly outlines all medical concerns and provides rationale for treatment along with functional restoration goals. These goals are objectified. A psychological assessment with objective psychological data was performed, which yielded objectifiably measurable goals. Dr. correctly notes in the denial that a peer review of records conducted on 05/03/2011 revealed "There are no lesions from the work injury identified in these records that would need surgical correction." It is clear that surgery is not an option. Beyond this, the reviewer has made a blanket statement and not indicated which treatments have not been exhausted. It is not possible to address each possible treatment and whether it has been provided. The reviewer should specifically state which treatment has not been provided so that issues can be addressed, in writing, in the appeal. According to the treatment guidelines, this level of treatment is appropriate for Mr. As stated above, the patient was referred

because prior treatment modalities had failed to decrease the pain and emotional distress, and had not facilitated the attainment of a functional status that would allow this person to return to work or have an improved quality of life. This patient has been highly compliant with lower levels of care and exhibits no indicators (and none are provided) for failure.

Summary: Based on the above information, it has been determined that this level of care is medically necessary for reducing this patient's pain experience, facilitating a timely return to the work force/job retraining and obtaining medical case closure. Thus, the following request is respectfully submitted: 97799 - Chronic Pain Management Program, 80 hours outpatient.

8-18-11 Utilization Review performed by PhD., notes he discussed this case and requested procedure with Dr. The clinical indication and necessity of this procedure could not be established. The psychological evaluation of 5/24/11 finds impressions of pain disorder and adjustment disorder. However, this is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The psychometric assessment (see below) is inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms, and to help design and predict response to treatment; and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e., pain complaint, behavior, and disability), to enable a "better understanding of the patient in their [sic] social environment," or to provide "a cogent explanation for the identified complaints and dysfunction." [Sanders, S., et al, (2005), Evidence-based clinical practice guidelines for interdisciplinary rehabilitation of chronic nonmalignant pain syndrome patients. *Pain Practice*, 5(4), 305-315, p. 306; Official Disability Guidelines. (2011). Pain; ACOEM. (2008). Chronic pain. *Occupational Medicine Practice Guidelines*, 2<sup>nd</sup> ed.; pp. 319-520, 3311. The test results are not integrated in the above evaluation. Appropriate interpretation of psychological tests involves "synthesizing all relevant data (e.g., medical, historical)" with test results, consideration of various "characteristics of the person," and adequate clinical/behavioral correlation [Camara, W. J., et al. (2000). Psychological test usage: Implications in professional psychology. *Professional Psychology. Research and Practice*, 31 (2), 141-154, p. 147; APA. (2002). Ethical principles and code. *American Psychologist*, 57(3), 1060-1073, Standard 9.06]. This is not evident here. It is not clear what is maintaining these complaints. The evaluation of this patient is not a "complete diagnostic assessment" [Official Disability Guidelines. (2011). Pain]. There is no current history and physical by the medical director or a physician associated with the pain program. Reiterating the appeal letter of 45112, Dr. offers that Dr. FCE (functional capacity evaluation) of 4/13 "qualifies as the medical assessment" for this program. However, this is not satisfied by that FCE, which contains no thorough examination, ROS (review of systems), or diagnosis, There is no documentation or known finding that the patients treating physician (Dr.) has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. This is not addressed in the above note, which is actually now 4 months old and recommends a work hardening/work conditioning program. There is no examination which updates the assessment and suggests a chronic pain program. In addition, the physician proposed to be providing the medical management and drug weaning, Dr. sp?), has not yet examined the patient, A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, without these assessments [Sanders, S., et al. (2005). Evidence-based clinical practice guidelines for

interdisciplinary rehabilitation of chronic nonmalignant pain syndrome patients, Pain Practice, 5(4), 303-315; Official Disability Guidelines. (2011), Pain; ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2" ed.; p. 331; CARE. (2008). Interdisciplinary pain rehabilitation programs, Medical rehabilitation standards manual (pp. 223-229), Tucson, AZ]. He was not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended.

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

THE PATIENT HAS AN INJURY DATE OF xx/xx/xx. HE HAS HAD DIAGNOSTICS, PHYSICAL THERAPY, AND MEDICATIONS FOR HIS INJURY. HE REPORTEDLY SLIPPED ON ICE WHILE AT WORK AND INJURED HIS HEAD AND NECK. A PSYCHOLOGICAL EVALUATION DATED 5/24/11 NOTES THAT HE RATES HIS PAIN AS 5-7/10, HAS A BDI OF 24, BAI OF 35, AND FEAR-AVOIDANCE ISSUES. HE WAS DIAGNOSED WITH A PAIN DISORDER AND AN ADJUSTMENT DISORDER. HE WAS NOTED TO BE TAKING TRAMADOL, MELOXICAM, AND METRXATONE. A PHYSICAL FUNCTIONING EVALUATION DATED 4/13/11 NOTED THAT HE WAS AT A LIGHT/MEDIUM PDL WITH A REQUIRED PDL OF MEDIUM/HEAVY. THIS PATIENT HAD VERY LITTLE TREATMENT OVERALL PRIOR TO THE REQUEST FOR A CHRONIC PAIN MANAGEMENT PROGRAM. AT ONE POINT, A WH PROGRAM WAS RECOMMENDED BUT IT IS NOT EXPLAINED WHAT HAPPENED WITH THAT RECOMMENDATION. IT IS NOT CLEAR HOW THIS PATIENT'S PAIN AND REPORTED SYMPTOMS OF DISTRESS HAVE BEEN ADDRESSED BY HIS DOCTOR OR WITH LOWER LEVELS OF CARE. IT IS NOT CLEAR WHY HE HAS NOT ATTEMPTED TO RETURN TO WORK ON LIGHT DUTY OR TO REDUCE HIS MEDICATION USE. HE IS REPORTEDLY NOT A SURGICAL CANDIDATE. BASED ON THE AVAILABLE INFORMATION, THE REQUEST FOR CHRONIC PAIN MANAGEMENT X 80 HOURS CANNOT BE ESTABLISHED AS REASONABLE AND NECESSARY, PER EVIDENCE-BASED GUIDELINES.

**ODG-TWC, last update 8-23-11 Occupational Disorders - 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.

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)