

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Chronic Pain Management x 80 hours

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

05/07/12: Functional Capacity Evaluation Report by DC
06/06/12: Progress Summary by MA, LPC, LCDC with
06/13/12: UR performed by DC
06/19/12: Request for Reconsideration by DC with
06/26/12: UR performed by DC
07/12/12: Request for Independent Review by PhD with

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a female who was injured on xx/xx/xx when she was bending down counting tomatoes and a cart operating on a rail ran her over and knocked her forward to the ground. She was hit in her back and landing on her left side on a concrete curb sustaining injuries to her left shoulder and lower back. According to the provided documentation, a MRI of the shoulder was performed on 07/28/08 and showed a full thickness small tear of the insertion region of the supraspinatus tendon, mild tendinopathy supraspinatus and long head biceps

tendons. She underwent Arthroscopy of the left shoulder with arthroscopic subacromial decompression and glenohumeral synovectomy on 08/21/08. It was reported the claimant has not returned to work and continues to have complaints of pain in her left shoulder.

On May 7, 2012, the claimant underwent a Functional Capacity Evaluation. Her current medications were listed as Hydrocodone 7.5/500mg and Hydroprofen 800 mg. Based on the results, she tested at the sedentary physical demand level. Her job requires her to be able to function at a Medium physical demand level. It was reported she had no ability to raise her left shoulder to 90 degrees or higher. DC opined that due to her high pain levels and inability to use her left shoulder, she was unable to return to work at that time. That the claimant's condition had steadily decreased resulting in her use of prescription medication for over 1 year. A structured Chronic Pain Program was recommended due to her high pain levels and as a result of her psychological evaluation.

On June 6, 2012, the claimant was reevaluated by MA, LPC, LCDC, who reported that she had been attending the cognitive pain management session since 5/22/12 and had been consistent with her attendance. She had completed 9 of 10 sessions. 10 additional sessions of CPMP were being requested to focus specifically on helping the claimant internalize new coping skills, along with cognitive behavioral changes in perception or pain and healing that would carry her outside of the program and back into the outside world of work. *Behavioral Observations:* It was reported that the claimant felt better about herself and was motivated by the program. At that time, pain symptoms still appeared to be impairing her work, social and personal functioning, however, she was making considerable progress in her ability to cope with the pain related symptoms. It was also reported that the claimant continued to exhibit interest and commitment in the program and that upon entering the program she was suffering from severe fear of future re-injury and other return to work concerns; however, after completion of her approved sessions in the chronic pain program, she was continuing to understand that her fears were not only irrational in nature, but also holding her back from a successful recovery. The claimant had voiced not only desires to return to work when she had emotionally and physically recovered from her injury, but had also discussed with the therapist her want to participate in future programs, such as DARS, to promote her return to work preparation and success. *Pain:* The claimant reported that before entering the program she was taking her medication as prescribed by the doctor; however, after completion of group therapy sessions of the program, she reported that she had reduced her medication intake to an as needed basis. The claimant voiced considerable interest in managing her pain without the dependency of medication. The claimant continued to report that she was managing her medication and pain better than before entering the program. *Beck Depression Inventory-II, Beck Anxiety Inventory, and Screener and Opioid Assessment for Patients in Pain:* The claimant was administered the BDI-II and scored a 33, within the severe range of the assessment. After completion of nine sessions of CPMP, she scored a 32. The claimant was administered the BAI and scored a 19, within the moderate range

of the assessment. After completion of nine sessions of CPMP she scored a 15. *Summary:* It was reported the claimant continued to progress toward her goals and ability to improve in the daily activities of her life. She was learning adequate coping mechanisms to deal with the multifaceted deficits that are occurring as a response to her injury. It was opined that the claimant demonstrated the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce. A detailed treatment plan was provided with outcome goals.

On June 13, 2012, DC performed a UR. Rationale for Denial: The claimant has already completed 10 days of a chronic pain program. The claimant's depression was in the severe range and has decreased by 1 point and the anxiety score was in the moderate range had decreased by 4 points. The claimant is still in the severe range for depression and the moderate range for anxiety. A follow up PPE or FCE was not performed or provided. The claimant began the program at the Sedentary PDL. The doctor states the claimant is currently at a light PDL, he doesn't know where in the Light PDL since no lift studies were provided. A recent functional evaluation has not been performed or provided with evidence of maximal effort as required for the current request. This also allows measuring functional progress and improvement as well as seeing what PDL the claimant is capable of performing in. A functional PDL can't be determined without any lift studies being performed or provided. The claimant has been weaned off Hydrocodone 5/500mg from 5 a day to 1 a day per the doctor; she is currently on no other medication. The claimant will be doing a retraining program with DARS, so she does not have a job to return back to currently. Weaning off medications does not require the requested program according to the evidence based guidelines, ODG. This claimant's date of injury is over 2 years old. The negative predictors have not been addressed. Documentation that the claimant is willing to change has not been provided. There is no written job verification from the employer for this claimant to return to, nor is there a job description/job demand per the employer to support the current request. The claimant does not meet the ODG Criteria for the current request.

On June 19, 2012, DC requested reconsideration of the denial for additional CPMP. Dr. Jackson states that "While progress has been made in the initial sessions, the additional sessions requested are intended to wean the medications to extinction and increase the functional capacity to the point where gainful employment is possible."

On June 26, 2012, DC performed a UR. Rationale for Denial: Discussed the request with Dr. on 6/25/12. The appeals correspondence did not address the issues raised by the previous reviewer and did not impact the previous non-authorization. There is minimal improvement noted on the BDI and BAI. Pain level's demonstrated minimal improvement. There is no indication the claimant has improved her strength, endurance or ability to perform activities of daily living. There is no compelling rationale for additional 10 sessions of chronic pain

management given the extremely minimal gains made after 9 sessions.
Recommend non-approval of additional 10 sessions of chronic pain management.

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

Denial of additional 80 hours of Chronic Pain Management is upheld/agreed upon since per ODG Pain Chapter, there is no objective improvement documented after 10 sessions. Submitted information reveals basically no change in psychometric testing for depression and anxiety, and there is no submitted information regarding functional improvement, and there are no clearly defined functional goals. The request for Additional Chronic Pain Management x 80 hours is denied.

PER ODG:

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). 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)**