



Specialty Independent Review Organization

DATE OF REVIEW: 2/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 80 hours of a Chronic Pain Management Program (97799).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 80 hours of a Chronic Pain Management Program (97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Underwriters Insurance Co.

These records consist of the following (duplicate records are only listed from onPain & Recovery Clinic IRO Fax Requests(LHL009) – 9/14/10 & 2/17/12, Pre-Cert Requests – 1/3/12 & 1/16/12, Pre-Auth Request Letter – 1/2/12, Request for Reconsideration letter – 1/16/12, Initial Medical Report – 11/14/11, Subsequent Medical Reports – 12/15/11, 1/16/12, & 1/31/12; Denial Letters – 8/12/10, 8/27/10, 1/6/12, & 1/20/12, Pre-Certification Letters – 10/22/09, 3/24/11, 3/28/11, 4/20/11, 5/18/11, 6/3/11, 6/30/11, 9/8/11, & 10/24/11, Notice of Disputed Issues and Refusal to Pay Benefits – 12/22/09; M.A., Behavioral Evaluation Report – 11/17/11; Functional Testing Work Capacity Eval report – 7/15/10, 11/1/11, & 12/15/11; Diagnostic MRI Left Elbow report – 11/5/09, Radiology Report –

7/21/10, MRI Left Shoulder w/o Contrast Report – 2/14/11; Diagnostic Center Radiology Report – 12/9/09; Health 7 Medical EMG-NCV report – 12/29/09; MD Consultation Report – 12/14/09, Office Visit Follow-up Note – 2/8/10; Medical Center Follow-up WC Visit Notes – 12/15/09 & 4/2/10, Progress Notes – 12/29/09 & 3/2/10, Physical Medicine & Rehab Treatment Plan – 4/2/10; Medical Consultants Networks RME report – 3/15/10; Focus FCE Report – 4/30/10; Spine & Rehab Centers Initial Medical Report – 6/3/10, Office Visit Notes – 6/15/10-1/20/12, Daily Patient Therapy Note – 9/12/11; Hand & Wrist Center Clinical Note – 6/18/10(x2); MD Initial Consultation Note – 7/1/10, Follow-up Consultation Notes – 7/29/10, 8/26/10, 9/17/10, 10/18/10, 11/18/10, 1/5/11, 1/27/11, 3/24/11, 4/21/11, 5/19/11, & 6/10/11; Drug Screen Results – 7/29/10, 11/18/10, 1/27/11, & 3/29/11; MD DDE Report – 8/2/10; Applied Assessments Notice of IRO Decision – 10/1/10; Diagnostics MMT & ROM reports – 10/18/10, 1/5/11, & 2/28/11; Toxicology Confirmatory Report – 11/23/10, 2/1/11, 3/29/11, & 6/14/11; ROC, PA New Patient Visit Note – 3/21/11, Electrodiagnostic Study Request – 3/21/11, Follow-up Visit Notes – 4/18/11-2/1/12, Procedure Report – 7/12/11, Post-Operative Visit Note – 8/31/11, Therapy Prescription – 10/5/11, Letter to DC – undated; Hospital ECG Report – 7/11/11; Anesthesia Record – 7/12/11; MD Prescriptions – 11/16/11, 12/15/11, 1/16/12, & 1/31/12; Health & Medical Practice Assoc. Initial Evaluation – 12/23/11; DWC69 – 1/17/12; and MD Report of Medical Evaluation – 1/17/12.

Records reviewed from Pain & Recovery: MD Letter – 2/9/12.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker was injured on xx/xx/xx when he slipped on a wet surface and fell onto his left upper extremity injuring the left elbow and shoulder. The first record for review was dated xx/xx/xx and was a letter indicating approval for physical therapy for the left elbow.

X-rays of the left elbow showed no fracture or dislocation, but metallic bullet fragments within the soft tissues adjacent to the radius from an old gunshot wound to the forearm. MRI of the left elbow performed on November 5, 2009 was said to show osteochondral lesions of the radial head and central articular surface of the capitellum. Tendon and ligament attachments were said to be maintained.

On December 14, 2009, a note from M.D. indicated that the worker fell onto his left elbow and had been treated with physical therapy. He was continuing to complain of pain, popping, clicking, grinding, numbness, and tingling. Dr. diagnosed a lateral more than medial epicondylitis and osteochondritis of the radial head and capitellum. He indicated that the worker had had an injection which did not improve his symptoms. He recommended another steroid injection, stretching, deep tissue massage, and ultrasound. He

stated that the worker could continue to work with restrictions of no heavy lifting, pushing, pulling, or overhead use.

On March 15, 2010, an RME was performed by M.D. Dr. stated that the elbow range of motion was normal and there was no swelling or crepitus. He stated that there was discomfort with elbow palpation. Motor and sensory function was said to be intact. Dr. reported that the diagnosis was bone contusion of the radial head and capitellum. He stated that there was no indication for further injection. He stated that symptoms should resolve with the passage of time. The injured worker needed no prescription medications, but could take over-the-counter analgesics and anti-inflammatory drugs. He did not think the worker would require work hardening or conditioning or further therapy.

On April 30, 2010, a Functional Capacity Evaluation was performed stating that the injured worker could perform at a light PDL and his job required a moderate PDL.

On June 3, 2010, the worker was evaluated by D.C. Dr. stated that the worker had injured his elbow and shoulder. His diagnosis was a left elbow internal derangement and left shoulder internal derangement. He recommended evaluation by an upper extremity specialist. On June 18, 2010, M.D. evaluated the injured worker and stated that he had excessive limb protection, extreme pain, over-reaction, and non-anatomic stimulation points using minimal stimuli. He stated that x-rays were normal. He stated that the MRI had shown signal intensity changes at the radiocapitellar joint. He stated that it might be appropriate to repeat the MRI to rule out osteochondritis dessicans or avascular necrosis.

On June 21, 2010, the injured worker began treatment in a chronic pain management program. He was evaluated by PAC for M.D. She noted that the injured worker had had physical therapy, a TENS unit, injections, and Gabapentin. She noted that he was taking Naproxen, a Lidoderm patch, Neurontin, and Vicodin ES.

Over the next almost two years, the injured worker continued to be followed in chronic pain management as well as by his chiropractor, Dr..

On August 2, 2010, a Designated Doctor, M.D., indicated that the injured worker was in so much pain in the shoulder and elbow that he could not "really evaluate muscle strength in the neck, shoulder girdle, and elbow." He diagnosed a contusion of the left elbow with median and ulnar neuritis and strain or sprain of the left shoulder with a rotator cuff tear. He stated that the injured worker was not at MMI.

The injured worker continued to be followed in chronic pain management and by his chiropractor.

On October 1, 2010, an IRO report was generated. This indicated that it was not clear that a complete diagnostic assessment had been made or that there was a detailed treatment plan to address his issues. The reason for his continued pain, depression, and dysfunction had not been clearly elucidated.

On February 14, 2011, an MRI of the left shoulder was performed. This showed a supraspinatus tendonopathy without tear, a small amount of subacromial bursa fluid, and mild hypertrophy of the acromioclavicular joint impinging on the rotator cuff .

On March 21, 2011, the injured worker began treatment with, M.D., a surgeon. Dr. stated that based on the mechanism of injury, the left shoulder and elbow symptoms should be compensable body parts. He stated that the injured worker had evidence of a shoulder impingement and cubital tunnel syndrome clinically. He recommended an x-ray of the left shoulder, a subacromial injection, and electrodiagnostic studies.

On March 24, 2011, D.O., a pain management specialist, suggested that the injured worker had been non-compliant with treatment plans.

On April 18, 2011, Dr. noted that electrodiagnostic studies had shown evidence of a left ulnar neuropathy at the elbow. He provided a subacromial joint injection.

The injured worker had a medial epicondyle injection on March 27, 2011.

On July 12, 2011, the injured worker was taken to surgery by Dr. for debridement and repair of a partially torn common flexor tendon. He recommended a formal therapy program on August 31, 2011.

The injured worker received 20 physical therapy sessions beginning in September 2011.

On October 26, 2011, Dr. indicated that the elbow remained symptomatic and that the injured worker was going to undergo four more physical therapy sessions and a Functional Capacity Evaluation. He stated that he was “under tremendous stress” due to his inability to work. A chronic pain management was recommended.

On November 14, 2011, M.D. evaluated the injured worker and diagnosed a left shoulder strain or sprain and internal derangement of the left elbow. He recommended a mental health evaluation, hydrocodone, and Mobic.

On November 17, 2011, a mental health evaluation was performed by MA, LPC. This evaluation included a Beck Depression Inventory which indicated that the worker had moderate depression with a score of 16. A Beck Anxiety Inventory showed moderate anxiety with a score of 15. The examiner concluded that the injured worker was under increased psychological stress, felt sad, had a loss of pleasure for usual activities, was restless, irritable and had difficulty concentrating. On November 30, 2011, Dr. indicated that the worker had completed formal therapy but noted little improvement. He indicated that the injured worker was scheduled to begin work hardening on December 15. Dr. indicated that there was a problem at the radial tunnel and on December 7, 2011 a radial tunnel injection was performed.

On December 23, 2011, M.D. examining the injured worker while Dr. was out of town, indicated that the injured worker was “cradling” his left arm. There was no swelling, his elbow was hypersensitive to palpation and showed guarding and limited range of motion due to pain. There was said to be decreased sensitivity to light touch over the fourth and fifth digits of the left hand.

On January 17, 2012, M.D. performed a Designated Doctor Evaluation and stated that the injured worker had been at clinical MMI on December 7, 2011 with 4% whole person impairment.

Dr. evaluated the injured worker last on February 1, 2012. At that time, he stated that the injured worker had “completed work conditioning.” He stated that the left elbow had “good range of motion” and “grip strength was good.” He indicated that there was sensitivity to the scar but that this was improving. Dr. stated that the symptoms were unchanged and were located in the left shoulder with certain activities.

A chronic pain management program has been recommended and denied as being not medically necessary on two occasions.

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

This worker was injured on xx/xx/xx when he slipped and fell landing on his left elbow and injuring both his shoulder and elbow. The voluminous records reviewed cover a two and a half year period following this injury seem to indicate that primary evaluation and treatment has been provided to the left elbow injury. Clearly, the shoulder problem is contributing to his chronic pain syndrome. Two designated doctors have evaluated this injured worker and stated that he had injuries to both the shoulder and elbow. It is also unclear as to why this injured worker, after the extensive treatment rendered to him over the past two and a half years, continues to have subjective complaints of pain at a level of 8 on a scale of zero to 10. It appears that the elbow symptoms have been fully and extensively treated and the injured worker’s surgeon, Dr. at the time of his last

examination stated that the elbow had “good range of motion” and that there was “good strength.” Dr. further reported that the injured worker had completed a work conditioning program and was at maximum medical improvement.

It appears to me, after reviewing this medical record, that the injured worker's shoulder is more than likely contributing significantly to his chronic pain symptoms. Dr. states that the injured worker's complaints now seem to be “located in his left shoulder” although in other areas of this medical record, it indicates that the injured worker continues to complain of elbow pain at a level of 8 on a scale of zero to 10. In the medical record, there is mention of possible cervical pathology contributing to this chronic pain situation and there is also a mention of a cubital tunnel syndrome or ulnar neuropathy at the elbow which was not addressed formally. The shoulder has been treated with injection and it is uncertain as to whether or not the shoulder has been treated with therapy.

ODG Treatment Guidelines indicate that although the work related injury is the main focus of treatment in the chronic pain program, other pathology that contributes to decreased function and pain should be addressed either prior to entering a program or coincident to starting treatment. It appears that this worker's shoulder symptoms have been partially treated but continue to contribute to his symptoms of pain. Prior to entering a chronic pain management program, pathology that could be contributing to the pain, even if it is not related to the initial injury, should be addressed since unless the involved pathology is addressed, the chronic pain management program is not likely to be successful.

This medical record does not contain information specifically as to how negative predictors of success will be addressed in this injured worker. The injured worker is apparently a smoker. Drug tests in the past have revealed evidence of marijuana metabolites in the patient's urine. There are statements that the injured worker was not completely compliant with his treatment program in that he did not give urine samples on at least two occasions. In order to qualify for chronic pain management, negative predictors of success must be identified and there should be evidence of how these negative predictors of success will be specifically addressed in pre-program goals.

In the behavioral medicine evaluation, there is a generic statement at the beginning that the injured worker does exhibit “motivation to change and is willing to undergo secondary gain.” There is a statement that one of the goals will be to reduce use of medications though there is no clear statement that the injured worker is willing to reduce his use of narcotic/prescription medications. He is on an extensive medication regime according to the records that are available.

In summary, this injured worker has chronic pain, but the pain appears to be coming from pain generating sources that have not been completely evaluated and treated. Negative predictors of success obviously exist in this case but there is no clear statement of how these negative predictors of success will be

addressed in the pre-program goal setting and treatment process. This injured worker and the medical record presented for review do not meet ODG Treatment Guidelines for entry into a chronic pain management program; therefore, the requested treatment is not medically necessary at this time.

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)**