CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: February 23, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program x 10 sessions

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 15 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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
11/28/11: Independent Medical Evaluation by
12/20/11: Request for Services by
01/18/12: Physical Performance Evaluation performed by at
01/25/12: UR performed by
01/26/12: Request for Reconsideration by
01/31/12: UR performed by
02/13/12: Request for Medical Dispute Resolution by

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was working when she injured on xx/xx/xx. She felt a sudden pain in her right shoulder. She was treated conservatively until a MRI revealed a type II acromion with some diffuse edema and possibly and at least a partial-thickness

tear of the rotator cuff and possibly a full-thickness tear. She was then referred to who performed arthroscopic debridement and subacromial decompression with excision of the coracoclavicular ligament and distal clavicle excision on July 29, 2010.

On November 28, 2011, performed an IME. reported that she had been exercising at home and rehabilitating. She was not taking any prescription medications. The claimant hand complaints of a little pain, but not much. Her primary complaints were of decreased motion of the right shoulder, particularly in abduction, flexion and internal rotation. On physical examination there was no tenderness to light palpation and there was no atrophy noted. Range of motion of the right shoulder in flexion was 110 degrees, extension 30 degrees, abduction 120 degrees, adduction 30 degrees, external rotation 40 degrees and internal rotation 40 degrees. Muscle strength of the right shoulder was somewhat difficult to assess due to the decreased motion noted. Diagnosis: Internal derangement of the right shoulder, postoperative state with some residuals. rendered the following opinions: I see no need for ongoing chiropractic treatment at this point. Basically, I feel that her office visits could be every month for two or three months, and then probably discontinued. The most important thing is for her to exercise at home with a diligent exercise program to increase her range of motion (pain does not seem to be a factor at this point). With regard to an endpoint in her treatment, I feel that within the next two or three months she should reach an endpoint to the necessity for treatment.

On December 20, 2011, submitted a Request for Services for 10 sessions of Behavioral Chronic Pain Management Program. Initial Recommendation: Patient has completed approved sessions of individual psychotherapy; unfortunately, patient was noted making minimal progress, due on large part to poor coping skills, anxiety, depression, and pain complaints. It was reported that before participating in individual psychotherapy sessions, the patient reported that her average level of pain was around a “6”. At this time, the patient reports that her level of pain could flare up to a level “4” with activity. The patient reports that physically and emotionally she did improve while performing physical therapy exercises in the work hardening program and attending approved individual psychotherapy sessions; however, her overwhelming fear of re-injury, along with a lack of solid coping skills, is holding her back from successfully achieving the level of performance which she needs to return to work and complete her necessary job requirements. It was reported that prior to individual psychotherapy she was administer BDI II and scored a 36, within the sever range of the assessment. Following completion of individual psychotherapy and a work hardening program she scored a 4 within the low range. On the BAI she originally scored a 14 and following individual psychotherapy and a work hardening program she scored a 2. Clinical Rationale for Requested Procedure: Being that patient has not been able to become stabilized enough to enhance coping mechanisms to more effectively manage pain and achieve success in rehabilitation, we are requesting that she participate in 10 sessions of a behavioral multidisciplinary chronic pain management program. In the multidisciplinary chronic pain management program, she will receive the tools needed to remove or address both psychological and physical barriers such as: improve coping skills, social skills, social support, improve self esteem, increase level of functioning, improve

vocationally and interpersonally, manage more effectively stress relate issues that may hinder progress in rehabilitation, address self defeating thought caused by outside circumstances continuing to have strong influence or hold on patient, help patient stay motivated and consistent with goals, decrease dependency on health care system, improve functioning interpersonally, minimize distress caused by anxiety, and depression related to chronic pain, and control over emotions and fears of the future. Treatment Plan Goals: 1. Encourage a change of focus from pain to functioning ability and return to a higher level of functioning. 2. Decrease pain and symptomology. 3. Improve functioning, physically, emotionally, and interpersonally. 4. Decrease dependence on healthcare system. 5. Decrease reliance on medication, as the patients coping skills improve. 6. Improve patient mobility through training and activity rest cycling, exercise program and physical therapy modalities within the individualized capabilities of the patient. 7. Decrease emotional distress, depression, anxiety, related to chronic pain from job related injury. 8. Improve sleep duration. 9. Aid patient in dealing with specific stress related issues that may hinder rehabilitation, including maladaptive beliefs regarding condition. 10. Address self –defeating thoughts. 11. Increase perception in her level of functioning. 12. Address isolation and hostility. There was also an outlined treatment plan.

On January 18, 2012, the claimant underwent a physical performance evaluation at by It was recorded that work as a is at a Medium PDL. Based on the results of the PPE, it revealed that the claimant was able to safely and dependably return to the usual and customary duties of a, per the job analysis provided by the claimant and/or employer. The claimant reported her neck and shoulder pain as a 1 on a scale of 0-10. She demonstrated the ability to safely and dependably perform at a Medium PDL.

On January 25, 2012, performed a UR on the claimant. Rationale for Denial: I discussed this request with on 01/24/12 at which time we reviewed the fact that the employee has already completed WH and the fact that an RME physician noted the employee complains only of a little pain. At this juncture, it does not appear that the employee has any significant loss of ability to function independently resulting from chronic pain and based on this information, the request is not in keeping with EBM and ODG guidelines.

On January 26, 2012, a Request for Reconsideration by indicated the following based on some of the ODG criteria: (1)(a) Patient requires assistance from family members and friends, on a regular basis, for basic daily activities of living and continues to rely on the treating doctor as a primary means of pain relief. (c) The patient has avoided engaging in any recreational or social activities. (d) Patient currently does not meet employer's physical demand requirement, as evident through attached functional assessment. (e) patient demonstrates a combination of symptoms of depression and anxiety, along with fears of functioning and problems with sleeping habits. (2) All lower levels of care have been exhausted. There are no additional treatment procedures pending. (8)(a) The patient does not have a negative relationship with employer. (b) Patient enjoyed working and is anxious to return to the workforce. (c) Patient seems motivated and is not discouraged about their future employment. (f) Patient does not

smoke. (13) Patient will be returned to the workforce or retrained at the completion of the program.

On January 31, 2012, performed a UR on the claimant. Rationale for Denial: The claimant is currently 1 year, 10 months post injury. The claimant has already completed a work hardening program for this work injury. The evidence based guidelines does not support repeating the same or similar program for the same work injury. The guidelines do not support using the current request like a stepping stone program following the completion of a prior return to work program such as work hardening program. After completing the work hardening program and psych sessions the claimant had very minimal depression and anxiety, neither were significant enough to support or warrant the requested program for this claimant. There is no evidence the claimant has a significant loss of ability to function resulting from the chronic pain. The claimant is not on any pain medication and the prior RME indicated the claimant has very little pain. There is no evidence the claimant has reached a plateau from PT already provided prior to this request. There is no evidence of attempts to return this claimant to modified work duties or full duty work status prior to the current request or following the completion of the work hardening program already completed. A return to work duties has the best long term outcome per ODG, even if the claimant requires a gradual transition to full duty work status. There is no written job verification from the employer for this claimant to return to, nor is there a job description or a job demand per the employer to support the current request. This claimant should be capable of modified work duties with a gradual transition to full duty work status as advised by ODG. Documentation that the claimant is willing to change has not been provided as required by ODG for the current request. The current request is not consistent with the evidenced based guidelines, ODG.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Denial of Chronic Pain Management is upheld/agreed upon. ODG Pain Chapter Criteria #2 for CPM is not met: previous methods of treating chronic pain have been successful in this case. PPE 01/18/12 demonstrates that the claimant meets functional job demands and psychometric testing after work hardening reveals improvement to normal levels.

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)**