SIRO

Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 8/23/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of a Chronic Pain Management Program 80 hours.

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 a Chronic Pain Management Program 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties:
These records consist of the following (duplicate records are only listed from one source): Records reviewed from:

Denial Letters – 7/16/12 & 7/27/12
Independent Medical Evaluation Report – 3/15/12
Reconsideration Requests for CPMP – 6/26/12 & 7/20/12
Request for Reconsideration Reports – 6/26/12 & 7/20/12
Request for Services Report/Treatment Plan – 5/9/12
Pre-Authorization Intake Form – 7/20/12
PPE Report – 5/4/12

Records reviewed from

Request for Independent Review – 8/9/12

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The documents provided for this review primarily consist of one Physical Performance Evaluation, an independent medical examination by a physician who had no doctor-patient relationship with the injured worker, requests for treatment programs and for reconsideration of adverse determinations, and

notifications from reviewers. The clinical history prior to xx/xxxx therefore must be derived from documents provided by individuals and entities who were not directly involved in the care of the injured worker.

The patient was injured on while in a confined space, picking up a piece of metal. Back pain and chest pain developed. The worker was evaluated at an emergency department where imaging scans were reported to show no acute injuries to the lumbar spine.

According to the records from an independent medical examiner, the worker received primary treatment including chiropractic care and physical therapy. The treating doctor diagnosed thoracic musculoskeletal injury with intercostal rib sprain/strain. Chest x-rays on 10/03/3011 were reported to show spondylosis deformans of the mid thoracic region.

On a functional capacity evaluation from 10/7/2011 the worker was reported to perform at the sedentary-light to light PDL.

Neurosurgery consultation was obtained in November 2011 wherein the consultant felt that there was no indication for surgical management of the condition. The examiner felt that the symptoms were primarily due to muscular strain and injury secondary to the accident.

The worker was found to be at MMI on or about 12/14/2011 with a 5% whole person impairment.

On an FCE dated 12/22/2011 the worker performed at a light to medium PDL . On the Physical Performance Evaluation from May 4, 2012 the worker reported a pain level of 3 on a scale of 0 to 10, with pain in the lower back radiating into the right sacroiliac joint. Lumbar spine range of motion was restricted. Back pain increased during static lift tests. The worker performed at a medium-heavy PDL. Dynamic lifting tests were suspended due to lower back pain, muscular fatigue and the worker reaching his maximum lift capability. Cardiovascular testing was limited by the development of symptoms of low back pain, dizziness, muscular fatigue at a MET level of 8.

On 5/09/2012 a request was submitted for 10 sessions of behavioral chronic pain management program.

An MRI of the lumbar spine on 10/18/2011 was reported to show multilevel facet arthrosis, spondylosis at T12, L1-L2 and L5, foraminal stenosis with displacement/compression of L5 nerve roots bilaterally, marked facet arthrosis and ligamentum flavum thickening at L4-L5 with bilateral neural foraminal encroachment at L3, mild facet arthrosis at L1-L2 through L3-L4. Plain film x-rays were reported to show evidence of diffuse idiopathic skeletal hyperostosis (DISH).

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

According to the ODG Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updated 08/10/12), pertaining to chronic pain management programs, the criteria for enrollment include the following:
(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.

The worker has had primary care, work hardening and psychotherapy. He has responded well to therapy with documented progress. Pain level and functional capacity have improved but he has not returned to the workforce. Although the worker is highly motivated to return to work, he specifically plans to return to his usual job, which may or may not be possible. The Physical Performance Evaluation on 05/04/2012 documents that the worker performed at a medium-heavy PDL but was unable to complete the cardiovascular component of the functional capacity evaluation because of the development of symptoms which included dizziness and muscular fatigue at a MET level of 8.0. A PDL of high requires an MET level of 6.4-7.5. This worker has a history of heart problems and may not be able to perform safely at a MET level of 6.4-7.5 on a full-time basis, in which case the treatment plan will need to address vocational options other than return to the same job. Apparently, the employer has not offered a job requiring a PDL less than high.

According to the ODG Integrated Treatment/Disability Duration Guidelines for Pain (Chronic):
In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the “pain” and not enough on functional restoration and gain

that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the “sickness” role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors.

The proposed CPMP would further address identified psychosocial factors. The worker meets the criteria for a diagnosis of chronic pain. The request for services dated 05/09/2012 documents some progress in response to psychotherapy, with a decrease of pain level from 5/10 to 4/10 and with some self-reported improvement while performing exercises. Regarding the physical and vocational issues resultant from the work-related injury, determination of suitability for participation in a CPMP may depend upon the outcome of a medical evaluation of the cardiovascular status.

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)**