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Notice of Independent Review Decision

DATE: May 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 80 Hours 97799

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

The reviewer is certified by the American Board of PM/Occupational Medicine with a secondary practice in Public Health with over 34 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:

01/14/13: Initial Behavioral Medicine Assessment
01/23/13: Referral for psychological testing, functional capacity evaluation, and chronic pain management
02/12/13: History
02/20/13: Chronic Pain Management Interdisciplinary Plan and Goals of Treatment from
02/21/13: Assessment/Evaluation for Chronic Pain Management Program
03/06/13: Followup Visit
03/06/13: Psychological Testing and Assessment Report
03/19/13: Physical Performance Evaluation
03/21/13: Preauthorization Request
03/26/13: UR performed
04/04/13: Reconsideration Request
04/18/13: UR performed
Patient Face Sheet

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her right elbow on the edge of a filing cabinet while working on xx/xx/xx. She is status post ulnar nerve transposition.

01/14/13: The claimant was evaluated for an initial behavioral medicine assessment. It was noted that she injured her right elbow on xx/xx/xx. She completed physical therapy and eventually underwent ulnar nerve transposition on 05/16/11. She completed postoperative physical therapy, which she stated made her pain worse. It was noted that an MRI dated 10/18/11 revealed an extensor tear. She then underwent three steroid injections in her elbow. She then underwent two nerve blocks with the third block pending. On this current visit she reported her pain as 9/10. She reported difficulties with activities of daily living as a result of her injury. On mental status exam/clinical observation/PSRS, noted her mood to be dysthymic while her affect was constricted. She scored 11 on the BDI-II, indicating minimal depression, and 12 on the BAI, reflecting mild anxiety. FABQ showed fear avoidance of work as well as significant fear avoidance of physical activity in general. It was noted that she would “greatly benefit from a brief course of individual psychotherapeutic intervention using CBT approaches and basic self-management strategies coupled with autogenic exercises to facilitate a healthy adjustment and improve her coping with her overall condition.”

02/12/13: The claimant was evaluated. She stated that a first stellate block helped her significantly and the second did not help her at all. She had been taking Naprosyn and Lyrica as well as rarely hydrocodone for pain relief. It was noted that she had incurred a secondary injury to the lateral epicondyle and was using an Aerodyne bicycle for rehabilitation after her surgery as well as had a couple of steroid injections in that area that seemed to be improving. It was noted that she smoked cigarettes in the amount of <1 PPD. On exam of the right elbow, she had a well-healed surgical scar over the ulnar groove. She was quite tender in that area to minimal palpation. She was also somewhat tender over the lateral epicondyle. stated that she was a reasonable candidate for chronic pain program and that she would likely not improve with additional injections.

03/06/13: The claimant was evaluated. She complained of stabbing pain down the arm. She stated that medications were helping somewhat. She was tolerating the Lyrica 75 mg and wanted to go up to about 100 mg. She was sleeping somewhat better. She did have an exacerbation of pain when she tried heat and hot tub as she did not tolerate heat or ice. On physical exam, she appeared rather anxious. Her teeth were clenched as she spoke. Her right elbow was generally tender. There was a livedo appearance. The tenderness was greater in the ulnar area than in the radial area. recommended a chronic pain management program, continue medications, and increase Lyrica.

03/06/13: The claimant was evaluated. On clinical review, she reported her average daily pain as 9/10. She reported difficulty with activities of daily living. She reported initial and sleep maintenance insomnia. Her mood was dysthymic while her affect was constricted. BAI score was 6. FABQ-W 42. FABQ-PA 24. She reported a moderately high level of anxiety. Her diagnoses included pain disorder associated with both psychological factors and a general medical condition, chronic. It was suggested that she participate in a chronic pain management program.

03/19/13: Physical Performance Evaluation from Injury 1 of noted that the claimant was not employed at the time of evaluation. It was assessed that she was unable to perform regular job duties. It was recommended that she participate in a chronic pain management program. There was no physician listed as performing the evaluation.

03/21/13: A request was submitted for 80 hours of a chronic pain management program. It was noted that she had completed six individual psychotherapy sessions and undergone psychological testing. She presently reported marked pain and unresolved functional problems associated with reliance on significant others to complete ADLs and unemployment. It was noted that she was unable to perform at her required PDL of medium and was currently assessed as being capable of a light PDL. She reported avoiding participation in family and social activities because of her pain. She scored 10 on the BDI-II, FABQ-PA 24, and FABQ-W 42. It was noted that she had not regained her pre-injury functional status after conservative care, medication management, surgery, injections, nerve blocks, physical therapy, and individual psychotherapy. It was noted that she continued to demonstrate functional deficits, marked pain, and sleep disturbance that were impacting her ability to safely return to work. It was noted that she required a more intensive, interdisciplinary pain rehabilitation program in order to resolve active symptoms on a long term basis, dismantle her disabled self-perception, increase her functional tolerances, and propel her toward a safe return to work. It was noted that her current PDL was light and her required PDL was medium.

03/26/13: UR performed. RATIONALE: The records reviewed indicate that the patient has been previously treated with medications, physical therapy, injections, psychotherapy, and other conservative treatments. A physical performance evaluation dated 03/19/13 indicates that the patient is unable to perform her regular job duties at the time of evaluation. A psychological evaluation dated 03/06/13, on the other hand, showed that the patient has minimal depression and anxiety (with BDI score of 10 and BAI score of 6). Her axis I diagnosis was pain disorder associated with both psychological factors and a general medical condition, chronic. It was recommended that the patient be approved for participation in a Chronic Pain Management Program. The report dated 03/21/13 states that the patient continues to complain of marked pain and unresolved functional problems that are associated with reliance on significant others to complete ADLs, and unemployment. It was noted that her treating doctor recommended participation in an interdisciplinary Chronic Pain Management

Program. The requesting provider stated that the patient's physical performance evaluation on 03/19/13 showed that she is capable of light physical demands at this time, while her required PDL is medium. Participation in a Chronic Pain Management Program was requested to increase the patient's functional tolerances for safe/successful return to work while reducing her perceived disability. The referenced guidelines state that prior to admission to a chronic pain management program, it should be demonstrated that previous methods of treating chronic pain have been unsuccessful and that there is an absence of other options likely to result in significant clinical improvement. It was mentioned that the patient has been treated with six sessions of psychotherapy, but there was no documentation provided of such sessions to evidence the said treatment. There was also no documentation found of the patient's response to these sessions. In addition, it also noted that for patients who have been continuously disabled for greater than 24 months, there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. Also, it was stated that a negative predictor of program completion and treatment efficacy is having elevated pre-treatment levels of pain. The psychology evaluation dated 03/06/13 indicates that the patient has an average daily pain of 9/10. notes patient takes Norco prn, needs medium physical demand level and is performing at light. He notes she is dysthymic presentation. It appears there is more of a psychological diagnosis with respect to chronic pain. With these reasons, the medical necessity of this request is not established.

04/04/13: A reconsideration request was submitted. The report stated that the claimant had not regained her pre-injury functional status after conservative care, medication management, surgery, injections, nerve blocks, physical therapy, and individual psychotherapy. It was noted that "we are aware that her injury is over 24 months." The goal was stated to be to decrease post-treatment care including needing medications, injections, and surgery. It was noted that she participated in six individual psychotherapy sessions and that she was able to make reductions in her pain, irritability, frustration, and anxiety. Her pain went from 9 to 7, irritability from 6 to 4, frustration from 6 to 4, anxiety from 7 to 4, BAI from 12 to 6. Her BDI-II went from 11 to 12.

04/18/13: UR performed. RATIONALE: This patient initially received therapy and medications for her elbow pain and swelling. She eventually underwent ulnar nerve transposition on 05/16/11 but remained symptomatic after surgery. Despite postoperative therapy, injections and medications, she alleges to be significantly symptomatic and disabled from activities of daily living and is unable to return to work. Her Functional Capacity Evaluation on 03/19/13 assessed that she is currently at a light PDL, which does not meet her work requirement of medium PDL. She was recommended to undergo chronic pain management for 80 hours. This recommendation was sent for utilization review and was non-certified because the patient's response to her recent psychotherapy treatment was not discussed, the presence of negative predictors of success (prolonged disability of more than 24 months and high pre-treatment levels of pain) and the predominance of psychological diagnosis with respect to chronic pain. An appeal for this request is made. The report dated 04/04/13 provides the patient's

response to individual psychotherapy treatments. The referenced treatment guidelines that lesser levels of care, including psychological treatments/therapy, should be exhausted prior to entry into chronic pain program. The patient, after six sessions of individual psychotherapy sessions, demonstrated improvement with pain levels (from 9 to 7), BAI score (12 to 6), irritability and frustration (6 to 4). Negative predictors of success are still evident in this patient, particularly her prolonged disability of more than 24 months, high pre-treatment levels of pain (7-9/10), and smoking (per 03/06/13 report). With the presence of negative predictors of success, medical necessity of the request is not established.

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

The previous adverse decisions are upheld. The claimant sustained a work-related injury to her elbow and underwent a surgical ulnar nerve transposition on 05/16/11 which resulted in subjective pain and elbow swelling. Postoperatively, she was treated with physical therapy, medications, steroid injections, and six psychotherapy treatments. She remained disabled from activities of daily living and is still unable to return to work. Her Functional Capacity Evaluation on 03/19/13 reveals that she is currently at a light PDL, and her job requires medium PDL to return to pre-injury status. A request was submitted for chronic pain management for 80 hours. This recommendation was sent for utilization review and was non-certified because of insufficient information about psychotherapy treatment was submitted and because this is a chronic injury of more than 24 months with high pre-treatment levels of pain and a predominance of psychological overlay with respect to chronic pain. An appeal for this request was made. The report dated 04/04/13 provides the claimant's response to individual psychotherapy treatments and references an improvement in pain levels (from 9 to 7), BAI score (12 to 6), irritability and frustration (6 to 4). Prolonged disability of more than 24 months, persistence of high levels of pain at 7/10 despite high levels of medication and psychotherapy do not bode well for a good outcome in this claimant. As per ODG, there is conflicting evidence in the referenced treatment guidelines that chronic pain programs provide return-to-work beyond this period. With persistence of chronic pain, high psychological overlay, poor response to other treatment modalities, medical necessity of the request is not established. Therefore, the request for Chronic Pain Management Program 80 Hours 97799 does not meet ODG criteria and is not certified.

ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> 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,</p>
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	<p>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.</p> <p>(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.</p> <p>(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:</p> <p>(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;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected;</p> <p>(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;</p> <p>(d) An evaluation of social and vocational issues that require assessment.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>
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	<p>positive outcomes in this population.</p> <p>(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.</p> <p>(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.</p> <p>(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).</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> 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.</p>
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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)**