

Health Decisions, Inc.

**4517 Coconino Court
Fort Worth, TX 76137
P 972-800-0641
F 888-349-9735**

Notice of Independent Review Decision

[Date notice sent to all parties]: 01-21-14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management over 2 weeks

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 18 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:

08-14-12: X-ray Right Wrist
08-14-12: MRI Right Wrist without Contrast
09-12-12: Office Visit Report
10-22-12: X-ray Right Elbow, 2 view
12-05-12: Office Visit Report
01-28-13: UR regarding 80 hours of chronic pain management program for the right elbow: denied
02-11-13: Designated Doctor Evaluation
04-09-13: Clinical Encounter Summaries
05-29-13: Patient Re-Evaluation
06-06-13: EMG/NCV of Bilateral Upper Extremities Report
06-17-13: Designated Doctor Evaluation
08-19-13: RME

09-12-13: Physical Performance Evaluation
09-30-13: Request for Services
10-11-13: Pre-Authorization Request
10-15-13: UR
11-14-13: Request for Reconsideration
11-14-13: Pre-Authorization Request
11-19-13: UR
01-28-13: Appeal Prospective

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He sustained injuries to his right elbow. He underwent right elbow ORIF for the ulnar olecranon fracture on February 14, 2012. He had 19 post-op PT visits and 160 hours of work hardening. Other treatment has included muscle relaxants and pain medication, and 6 months of massage therapy and 6 months of Home Tens Unit.

08-14-12: X-ray Right Wrist. Impression: 1. Osteoarthritic changes as detailed about without acute fracture or dislocation.

08-14-12: MRI Right Wrist without Contrast. Impression: 1. Peritendinitis involving the extensor carpi radialis longus and brevis tendons. 2. Radiocarpal and intercarpal arthritic changes. 3. Small septated cyst or loculated fluid adjacent to the ulnar styloid and ulnar styloid attachment of the triangular fibrocartilage.

09-12-12: Office Visit Report. The claimant presents with gradual onset of constant episodes of moderate right entire elbow and wrist pain. The claimant rates pain 7/10. The symptoms are improved by immobilization, non-opioid analgesics and restricted activity. The symptoms are worsened by motion at the elbow and wrist, forearm rotation, use of the hand, lifting, throwing and direct pressure. Current meds are Hydrocodone-Acetaminophen 5-500mg oral tabs and therapy. Assessment: 1. Closed Fracture of Proximal End of Ulna. 2. Bursitis of the Wrist. Recommendations: 1. Physical Therapy 3xwkx4wks, followed by WCP x 4weeks. 2. XR Elbow.

10-22-12: X-ray Right Elbow, 2 view. Impression: 1. Stable appearing fracture of the proximal ulna and olecranon process with secondary arthritic changes and likely olecranon bursitis. Posterior spur formation noted.

12-05-12: Office Visit Report. The claimant presents today with right entire elbow and wrist pain. Associated symptoms include decreased ROM, swelling and pain in the hand. Symptoms otherwise unchanged from previous visit. Past Diagnostic Test Results: 11-19-12 Elbow Right CT: 1. Comminuted fracture of the olecranon stabilized by compression plate and screws. Several small fragments are seen particularly along the proximal and lateral aspect of the olecranon within the posterior soft tissues. 2. Radicapitellar and ulnotrochlear arthritic change. 3. Note is made of some thickening and edema along the distal

triceps tendon; however, the tendon appears grossly intact. 09-12-12 X-Ray Elbow MIN 3V: Right: Internal fixation with two plates and screws in the olecranon and proximal ulna. In good position no loosening. Fractures, intra-articular and extra-articular are healed without deformity. 09-12-12 X-Ray Elbow Complete Right MIN 3V: 1. Plate and screw internal fixation of the olecranon is demonstrated; bones appear well-aligned and positioned. There are prominent secondary degenerative changes noted at the joint space, articular incongruity of the olecranon is visible. 2. No acute fracture or dislocation is seen. 3. Small joint effusion is suspected. Recommendations: 1. Meloxicam 15 mg. 2. XR Elbow.

04-09-13: Clinical Encounter Summaries. The claimant presents with pain in the right arm about a level of 4-6/10. The claimant's physical exam revealed right elbow ROM is -25 extension and 90 degrees of flexion. Stable elbow and TTP over the triceps and pain into the triceps with PROM of the elbow into flexion. Discussion: The claimant has limited ROM d/t scar tissue post-op. He may benefit from a dynasplint to improve ROM of the right elbow. He has significant arthritic changes in the right elbow joint. He can try PROM with a dynasplint and possible steroid injection into the radial capitellar joint if necessary.

05-29-13: Patient Re-Evaluation. The claimant presents with pain in the right elbow and wrist. Palpation of the right upper extremity continues to note pain along the right elbow region extending into the wrist. Cozen sign and Mill sign were positive for increased weakness and pain in the right forearm region. Tinel sign was negative for numbness and tingling. Phalen sign was positive for increased pain in the right wrist. Finkelstein test was also positive for pain in the right side. DTR noted triceps 0/5 on right. Girth measurement seen today right bicep at 33 cm, left bicep 35 cm, bilateral forearms at 34. Impression: 1. Ulnar fracture, 2. Internal derangement of the wrist. Plan: Follow-up and NCV/EMG.

06-06-13: EMG/NCV of Bilateral Upper Extremities Report. EMG Findings: There is no evidence of spontaneous activity, positive sharp waves and/or fibrillations recorded. Interpretation: Electroneurographic documentation is unremarkable for cervical radiculopathy and/or peripheral entrapment syndromes at this time.

06-17-13: Designated Doctor Evaluation. The claimant's chief complaints are the right elbow and wrist. Motor/Sensory complaints are numbness, pins/needles, tingling and weakness of the right arm. Pain ranges from 5/10 to 10/10. The claimant indicates that the following activities increase pain: reaching, sleeping, lifting, sexual activity and carrying. The claimant indicated that nothing decreases the pain. Joint palpation of the elbow indicated tenderness over right olecranon bursa and with attempted right triceps extension. Atrophy was noted in the right biceps. Tested negative for Tinel's signs and positive for Cozen's and Phalen's signs. Clinical MMI was assigned as 06/17/13 because of the following rationale: On multiple visits since April of 2013, both I and the examinee's treating providers recommended right elbow cortisone injection, dynasplint and chronic pain management, none of which has been performed. At this time, the examinee has residual symptoms of functional impairment but has completed post-operative

physical therapy and a work hardening program. Based on the medical records, the fracture has healed and his imaging shows the fracture is stable. Although I still believe the above mentioned treatments are necessary, since the insurance carrier has refused to approve the recommended treatment, the examinee is at MMI today, based on today's exam and record review with the following impairment rating based on his residual decreased right elbow range and decreased grip strength.

08-19-13: RME. On xx/xx/xx the claimant was diagnosed with fracture, right olecranon and on 02-14-12 open reduction and internal fixation of right ulnar olecranon fracture was performed. The claimant complains of pain all day and night in his elbow, down to his wrist. The pain is most severe with movement of the arm. Sometimes using his elbow wrap reduces the pain. He rates his current pain 8/10. On palpation there was tenderness to the right medial and lateral distal humerus. There was right elbow pain with self-administered axial compression. Diagnosis: Fractured right elbow olecranon and proximal ulna. opined that the claimant reached Maximum Medical Improvement as of December 10, 2012, the date he underwent a Functional Capacity Evaluation and was able to reach Heavy Duty work ability. opined he plateaued at that point.

09-12-13: Physical Performance Evaluation. The claimant indicates difficulty in holding objects with the right hand and increased right elbow pain with movement. States current pain level is 4/10. Prior Work Demands: Very Heavy PDL, up to 80 lbs frequently. After completing the NIOSH Static Lift Tests, the claimant reported increased pain in the right wrist and elbow. Dynamic Lift Tests were suspended due to increased right elbow and wrist pain, muscular fatigue and patient reaching his maximum lift ability. The claimant demonstrated restricted ROM in the right wrist and elbow, when compared bilaterally. The claimant demonstrated a strength deficit in the right elbow, wrist and grip, when compared bilaterally. Overall, the claimant demonstrated the ability to safely and dependably perform at a Medium physical demand level, which fails to meet the minimum job requirement for his prior job.

09-30-13: Request for Services. Initial Recommendation: Patient has participated in individual psychotherapy sessions; unfortunately, patient was noted making minimal progress, due on large part to poor coping skills, anxiety, depression, and pain complaints. Request for 10 sessions of Multidisciplinary Chronic Pain Management Treatment to aid the patient in dealing with depression, anxiety, and pain symptoms associated to both psychological factors and a general medical condition. Behavioral Observations: Some of his stressors include his lack of financial stability and his lack of overall physical functioning. He reported having difficulty maintaining his levels of pain low enough, for a period of time, so that he can productively function. Because of his high level of daily stress, he has been unable to effectively cope with his pain. Psychotherapy Outcomes: Limited psychotherapy proved to be mildly useful and helpful, as evidence by patient's rapport with the therapist and his willingness to share his feelings and talk openly about his problems. Unfortunately, this limited amount of therapy was insufficient to meet the patient's needs. He had shown progress in

decreasing his levels of pain throughout treatment. His average level of pain is around a 4. He reported that physically and emotionally he did improve while performing physical therapy exercises along with psychotherapy session; however, his overwhelming fear of re-injury, along with a lack of solid coping skills, was holding him back from successfully achieving the level of performance which he needs to return to work. BDI-II score was a 20 and after completion of several group session was an 18. BAI was a 10 and after completion of group session was an 8. FABQ work scale was 33 out of 42 and Activity scale was 18 out of 24. Requirements for ODG, it was noted that: The claimant 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. The claimant has avoided engaging in any recreational or social activities. He demonstrates a combination of symptoms of depression and anxiety, along with fears of functioning and problems with sleeping habits. He currently relies on narcotic pain medication for their primary means of pain relief. There are no additional treatment procedures pending. The claimant does not have a negative relationship with his employer and is anxious to return to the workforce. He is motivated and not discouraged about future employment. Treatment Plan Goals: 1. Encourage a change of focus from pain to functioning ability and return to a higher level of functioning. 2. Decreases 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 asleep 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 his level of functioning. 12. Address isolation and hostility. A Treatment Plan was presented.

10-15-13: UR Rationale for Denial: According to the Official Disability Guidelines regarding chronic pain management programs, criteria includes: "Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." It appears that the patient has already had the extensive amount of treatment for his chronic pain condition including surgery, postoperative physical therapy, and work hardening, and there was mention from a previous required medical examination report on 08/19/13 that the patient had already achieved a heavy duty work capability status as of 12/10/12 from a Functional Capacity Evaluation and that he had plateaued at that point and was at maximum medical improvement as of 12/10/12, and this would not support the need for the patient undergoing treatment in a multidisciplinary chronic pain management program setting, as he was already functioning at a high-level capacity. In this case, with the high level of functioning already occurring, this appears that the patient did have significant clinical improvement from the various treatments received and this would not

support the need for the chronic pain management program at this point. Therefore, this request is not medically reasonable or necessary.

11-18-13: UR. Rationale for Denial: In this case, the injured worker is one year and nine months post-surgical repair of a fractured right olecranon and proximal ulna. He was placed at maximum medical improvement in August 2013. He has undergone appropriate medical treatment including passive and active physical therapy, medication management, and surgical repair of fracture, work hardening program, and behavioral chronic pain management sessions. A 09/12/13 physical performance evaluation noted pain of 4/1, decreased, and range of motion was decreased, however, within functional range of motion at the wrist and elbow. Also, he has demonstrated the ability to safely and dependably perform at a medium level of physical demand level. A clinical note of 08/19/13 reflects that he is at maximum medical improvement and that the patient had reached heavy work duty ability. The request does not meet the criteria of the guidelines in that there is minimal functional loss noted in that this gentleman is function at a medium level of functional capacity. He has completed work hardening and physical therapy, both passive and active at this point. Also, there is no indication of excessive dependence on health care providers, spouse, or family and there is no indication of physical deconditioning or social withdrawal or development of psychological sequella that limits function. Therefore, medical necessity of this request has not been established.

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

Denial of 80 hours of Chronic Pain Management is upheld/agreed upon. The claimant completed 19 post-operative Physical Therapy sessions and 160 hours of Work Hardening and attained HEAVY job capabilities over one year ago. There is stated "minimal progress" as evidenced by little to no movement in psychometric testing after more recent individual and group behavioral sessions. There is question regarding compliance with fitness maintenance and behavioral techniques to warrant repeating yet another multidisciplinary rehabilitation program. Therefore, the request for 80 hours of chronic pain management over 2 weeks is not medically necessary.

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)**