

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** May 8, 2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management Initial 10 Sessions, CPT 97799

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

This physician is Board Certified in Anesthesiology with over 14 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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who sustained a work related injury on xx/xx/xx when a fire extinguisher landed on her foot.

xxxxx: Encounter Note. Claimant complained of continued pain and is on crutches and wearing a splint, pain is moderate with a rating of 8/10, described as aching, intermittently. Since the onset, she reported the problem as unchanged and made worse with walking experiencing numbness. Ankle Examination: deformity: posterior and lateral displacement along with no rotational deformity noted about the long axis of the low leg and supination of the foot. There is minor swelling of the lower leg centered at the ankle. The lower leg is tender both medially and laterally to light and deep palpation at the distal aspect near the

ankle. Tendon function of the lower leg is intact but pain is reproduced both actively and passively. Diagnosis Codes: 845.00 sprain/strain of ankle unspec, 924.20 contusion of foot. Impression: Trimalleolar fracture, closed. Treatment Plan: a course of physical therapy was recommended. Claimant to return in 2 weeks for follow up.

09-20-13: MRI Left Foot Without Contrast. Conclusion: 1. Relatively prominent fluid is seen in the subtalar joint without evidence of sprain of the cervical ligament and talocalcaneal ligament of the subtalar joint. 2. There is developing subchondral cystic change along the dorsal neck of the talus. No definite area of fracture is demonstrated. 3. Moderate fluid is seen in the first MTO joint. There is also moderate fluid in the tibiotalar joint. 4. No additional findings are seen.

10-08-13: Initial Visit. Claimant complained of sharp left foot pain 8/10 with swelling that is aggravated by walking and standing too long in one position which increased pain. Palliative factors: therapy helped some. PE: Musculoskeletal: Left foot: ROM of the left foot is painful on end ranges. There is tenderness over the dorsal aspect of the foot. There is pain overlying the first metatarsal phalangeal joint with pain on palpation with severe edema present. ROM is pain full on end ranges. Motor strength is 4/5. There is no neurovascular deficits. Assessment: Claimant with chronic left foot pain with subtalar joint effusion. 1. Traumatic foot injury with joint edema. 2. Left foot contusion. Plan: The claimant may benefit from a joint injection in the first metatarsal joint to deliver medication directly to the area of pain. Claimant was provided with pain medication to decrease pain and swelling during rehabilitation. The injection will decrease the pain and swelling and facilitate ROM in a pain-free manner. Medication: prescribed Ibuprofen 600mg.

10-22-13: Procedure Note. Procedure: Intra-articular joint injection left foot (first metatarsal). Diagnosis: Traumatic left foot injury with joint edema (first metatarsal).

01-10-14: Job Description. Job requirements: occasionally lift 50lbs, bend, kneel, squat, and climb steps along with periods of standing and walking.

02-04-14: Office Visit. Claimant stated that the injection helped about 70%, s/p injection pain rated 4/10. She stated that she feels discomfort while walking and has slight pain to her foot. She stated that if she stands for long periods of time that her foot starts to swell. Objective: left foot pain. PE: Musculoskeletal: Left foot: ROM of the left foot is painful on end ranges. There is tenderness over the subtalar joint with effusion present. ROM is painful on end ranges. Motor strength is 4/5. Assessments: Patient with chronic left foot pain with subtalar joint effusion. 1. Traumatic foot injury with joint edema. 2. Left foot contusion. Plan: Proceed with 2<sup>nd</sup> injection in the subtalar joint, this in conjunction with PT s/p injection should resolve any residual pain.

03-13-14: Work Hardening Exit Evaluation. The claimant has completed 20 days of work hardening. She reported the following: pain 5/10, continued depression,

anxiety and worry, improved motion and strength of the left ankle and foot, improved ability to lift weight from floor level, increased ability to perform repeated cardiovascular exercise, continued medication use for pain relief and daily function, increased motivation to return to employment, fear of further injury, increased ability to stand and walk without rest periods. Plan: The claimant is required to meet the demands of a minimum of a medium-heavy physical demand to return to her position. The claimant has progressed well with the program with improved physical capacity. She has reached a light-medium PDL after beginning the program at a sedentary PDL. The claimant has increased strength, foot/ankle ROM, improved gait and increased continuous weight bearing ability. However, it is apparent that the claimant continued to display chronic pain behavior as well as dependence on pain medication. The claimant is experiencing continued depression though she benefited from the limited psychological treatment during the work hardening program. She is having difficulty coping with strength and work capacity limitations that are likely to continue as a result of the trauma to the lower extremity. The psychological deficits should be addressed prior to returning her position.

03-20-14: Office Note. Claimant complained of left foot pain 5/10, decreased difficulty walking or standing with support. The claimant is able to tolerate 30 minutes of continuous walking or standing and continued to use pain medication daily and stated that the two injections did not have lasting effects. ADL's include difficulties with: standing, stairs, steps, driving, walking, any weight bearing. PE: Tenderness dorsal aspect of the left foot: severe. Dorsiflexion and plantarflexion +5, inversion and eversion +4. Diagnosis: 1. Left foot pain d/t trauma, 2. Traumatic foot injury w/ joint edema. Treatment Plan: Claimant will undergo psychological evaluation for participation in CPMP with goals of decreased pain, increased coping skills, and return to employment upon program completion. The program will also focus on weaning the claimant off pain medication and focus on non-pharmacologic pain control measures. She has benefited from aggressive rehabilitation and work stimulation. However, the psychological deficits were only partially addressed through limited individual sessions. A chronic pain program will prepare the claimant for return to employment and wean the claimant off of pain medication. She is not a surgical candidate so it is expected that the claimant will return to unrestricted work following completion of a CPMP.

03-20-14: Initial Assessment & Evaluation. Baseline Information regarding identified problem areas: Average pain 5/10; BAI-15, moderate; BDI-II-20, moderate; FABQ: FABQPA-2/24, FABQW-19/42; GAF-60; PDL-Light/Medium; Medication: Ibuprofen 600mg. Diagnostic Impression: 729.5 pain in limb, 845.10 sprain in foot, unspecified site, 928.20 The crushing injury to foot, 307.89 pain disorder associated with both behavioral factors and a general medical condition, Chronic pain syndrome. Treatment Recommendations: The claimant is a candidate for a multidisciplinary program, which consist of 20 sessions, however, it is recommended that the claimant participate in 10 sessions of a CPMP to insure that her medical benefits is entitled and a con-current to assess her compliance and therapeutic response to treatment.

04-03-14: UR. Reason for denial: Past treatment is documented to have included 13 sessions of physical therapy, as well as 20 sessions of a work hardening program. A medical document dated 3/20/14 indicated that subjectively, pain was described as a five on a scale of 1 to 10. Objectively, there was documentation of tenderness to palpation over the dorsum of the left foot. There was documentation of an ability to dorsiflex the left foot 20 degrees and plantarflex the left foot 30 degrees. A medical document dated 6/3/13/14 indicated that the claimant completed 20 sessions of a work hardening program. It was documented that the claimant was capable of light-medium duty work activities. The claimant commenced the program capable of sedentary work activities. A MRI of the left foot obtained on 9/20/13 revealed findings consistent with the presence of fluid in the subtalar joint. There was also evidence for fluid in the first MTP joint. It is documented that on 10/22/13, an intra-articular joint injection was provided to the left foot. Peer to peer was successful and the opinions set forth by the designated representative are very much respected. However, in this particular case, for the described medical situation, the above noted reference would not support this specific request to be one of medical necessity. The above noted reference would not presently support such an extensive program to be one of medical necessity, as recent treatment was recently completed in the form of a tertiary program, a work hardening program, for 20 sessions. As a result, presently, medical necessity for this specific request is not established per criteria set forth by the above noted reference which states "at the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program; Adverse determination.

04-16-14: UR. Reason for denial: After reviewing the submitted pages of appealed documentation, the claimant sustained a non-surgical injury to the left foot. The claimant has received 13 sessions of PT and 20 sessions of work hardening, yet still has not returned to modified or full work duties with no clear reasoning as to why this claimant, who does not have an injury to the low back, neck or upper extremities would not return to her normal physical demand level following 2 weeks of intensive work hardening. The FCE noted she could stand for 30 minutes without increase in pain. The request does not appear to be medically necessary. The claimant should do just as well with a return to modified duties and a self-directed home exercise program. Recommend non-approval of 10 sessions of CPMP.

04-30-14: Encounter Note. Claimant presented with continued 5/10 left foot/ankle pain with no notable changes presented. Diagnosis Codes: 719.47 pain in joint ankle/foot left, 337.2 reflex sympathetic dystrophy left. Impression: Foot pain with concerns of possible RSD/complex regional pain disorder secondary to the crush injury. Treatment Plan: An MRI of the left foot was ordered. A 3 phase bone scan was ordered. On the basis of clinical evidence lab studies have been ordered. Return in 3 weeks for follow up.

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

Previous adverse determinations are upheld and agreed upon. The claimant sustained a non-surgical injury to the left foot and has subsequently received 13 sessions of PT and 20 sessions of work hardening. It is unclear, despite this therapy, why the claimant has not yet returned to modified or full work duties. The claimant does not have an injury to the low back, neck or upper extremities and should have returned to her normal physical demand level following 2 weeks of intensive work hardening. The FCE noted she could stand for 30 minutes without increase in pain. The request does not appear to be medically necessary. The claimant should do just as well with a return to modified duties and a self-directed home exercise program. Therefore, after reviewing the medical records and documentation provided, the request for Chronic Pain Management Initial 10 Sessions, CPT 97799 is not medically necessary and non-certified.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p><b>Criteria for the general use of multidisciplinary pain management programs:</b>  <b>Outpatient</b> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(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.</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:  (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.</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>
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	<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 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). (<a href="#">Sanders, 2005</a>) 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</p>
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	<p>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 <a href="#">Chronic pain programs, opioids</a>; <a href="#">Functional restoration programs</a>.</p>
<p>Chronic pain programs, early intervention</p>	<p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <p>(a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity.</p> <p>(b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis.</p> <p>(c) Risk factors are identified with available screening tools or there is a previous medical history of <a href="#">delayed recovery</a>.</p> <p>(d) The patient is not a candidate where surgery or other treatments would clearly be warranted.</p> <p>(e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions.</p> <p>(f) Evidence of psychosocial barriers that make return to work unlikely.</p> <p>(g) Loss of employment or evidence of partial disability involving ability to perform only "part-time" work or work with "light-duty" restrictions for greater than 4 months. (Mayer, 2003) (Gatchel, 2003) For general information see <a href="#">Chronic pain programs</a>.</p>

**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)**