

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of Interdisciplinary Pain Rehabilitation for the left elbow/forearm at Functional Pain Center

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 16 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx and injured his left elbow. Initial treatment included Naproxyn and Medrol Dosepak with no relief.

On May 7, 2013, X-ray of the Cervical Spine, Impression: Besides indirect signs suggestive of possible muscle spasm, there are no significant acute abnormalities.

On December 16, 2013, the claimant was evaluated for left elbow pain. On examination he did not show much of any swelling around the elbow and had satisfactory ROM. There was vague discomfort around the medial epicondyle. There was fullness in the left proximal elbow area anteriorly, but pronation and supination was good. X-rays of the left elbow were benign. Impression: Pain left

elbow, soft tissue injury. Recommendations: MRI to rule out any soft tissue injuries.

On January 3, 2014, MRI of the Left Elbow, Impression: 1. A moderate joint effusion is present with no fracture or intra-articular loose body. 3. There is evidence of tendinitis of the common flexor tendon and sprain of the ulnar collateral ligament along the medial aspect of the elbow.

On January 13, 2014, the claimant was re-evaluated who found on examination no external deformity. He was tender over the triceps insertion. Elbow had complete extension and 120 degrees of flexion. Recommendations: Evaluation by an upper extremity specialist.

On March 26, 2014, the claimant was re-evaluated by for continued moderate pain of the left elbow. PT was noted to be denied. On examination there was tenderness of the medial epicondyle and the lateral epicondyle. There was also tenderness of the flexor carpi ulnaris and the ulnar collateral ligament. Active ROM with flexion of 132 degrees and extension of -8 degrees. Pronation and supination were normal, but there was pain, especially with supination. No instability and strength was 5/5. Assessment: 1. Sprain of ligament of elbow. 2. Pain in elbow. 3. Sprain, elbow joint, medial collateral ligament. Plan: Since specialized hand therapy was denied, recommended a corticosteroid injection.

On April 2, 2014, the claimant was re-evaluated who performed a Trigger Point Injection of the left elbow. Recommendations included using the elbow brace and avoid any kind of work until the following Monday, the return to work with no lifting, pushing or pulling more than 10 pounds with the left arm.

On May 9, 2014, the claimant was re-evaluated for continued pain. It was reported the injection helped him, but the pain returned and was concentrated over the lateral aspect of the left elbow. A Lateral Epicondylar Elbow Injection was performed. It was recommended he avoid any kind of use of his left hand until Monday and then return to restricted work.

On May 20, 2014, an FCE was performed. Subjective Complaints: At the time of the FCE, the claimant complained of moderate to strong pain in the right elbow area with activities of daily living. He also stated that he had difficulty performing his job while reaching horizontally as well as overhead reaching activity. Palpation elicited tenderness of the lateral aspect of the left elbow. Rom was: 48 degrees (1) Extension with pain, 180 degrees (1) Flexion with pain, 90 degrees (1) abduction with pain. Strength of Flexion Deltoid, Extensor Infraspinalis, Abductor, Bicep, Tricep were all 3/5. Wrist Extensor and Wrist Flexor were 4/5. It was felt true effort was demonstrated throughout the FCE and that he was functioning at a Sedentary Physical Demand Level. Evaluators Comments: demonstrated good effort and strong motivational skills to return to work. However, he has not met his required physical demand capacity job description he complains of strong pain while lifting over 15 pounds. Based on the results of

this evaluation may benefit from participation in a work hardening program to address physical and functional limitations noted on the FCE.

On June 6, 2014, the claimant was re-evaluated for continued minimum pain of the left elbow. It was reported the injection were improving the symptoms slowly. Recommendations included continuing with home exercises and limited duty.

On July 14, 2014, a request for 10 days (80 hrs) trial period of Pain Management Program Behavioral Health Assessment indicated: The claimant had been under treatment since 11/01/14 without significant gains. Treatment included physical therapy, passive modalities, home exercise regimen, injection therapy, and medication therapy. He has not returned to work without restrictions and was fearful of performing activities that may exacerbate his pain. He was motivated to participate in the Pain Program with the intention it would assist him in work ready status. On Physical Exam his ROM was: Flexion 100-135, Extension -5/0-5, Pronation 70/90, Supination 70/90. Digital palpation elicited increase pain and revealed tenderness on the left side. Motor strength testing of the upper extremities demonstrated weakness of the left UE with 3+/5. Conzens Test and Mills Test on the left were positive, indicating lateral epicondylitis. Subjective complaints included: decreased sleep, decreased movements with fine motor manipulation, hypertonicity of the left flexors/extensors of the elbow. A treatment plan was provided. It was noted that the claimant was motivated to change and willing to decrease his medication regimen. He also demonstrated eagerness to participate in vocational exploration to identify progressive alternative occupations through vocational testing. He expressed readiness and an eagerness to return to full-time employment. It was noted that overall clinical impression indicated the claimant was able to benefit from a pain program. His mental distress was elevated due to his pain, but he was not experiencing severe distress that would interfere with the success of an outpatient pain rehabilitation program. Diagnostic Formulation: Axis I: Pain Disorder, chronic. Axis II: none. Axis III: Physical disorders and conditions/Injury related pain. Axis IV: Psychosocial Stressors (PSS) 4, severe, chronic pain, threat of job loss, familial distress, financial distress and multiple financial/social/physical losses and hardships. Axis V: GAF: Current: 60. Prior to Injury: 90. Recommendations: Initial 10 day (80 hours) trial of ODG pain management program.

On July 18, 2014, UR. Rationale for Denial: Official Disability Guidelines-Treatment in Workers' Compensation indicates chronic pain management programs are for claimants who are on medication where there is evidence of prescription pain medication use that may result in tolerance, dependence, or abuse. The claimant is on no opioid pain medication. There is no documentation there is a lack of options likely to result in significant clinical improvement. There is no documentation the claimant has undergone a cortisone injection to the elbow. No imaging was provided for review. The records do not reflect the claimant is not a candidate for surgery. The request for an interdisciplinary pain rehabilitation for 10 visits, eight hours a day, five days a week to the left elbow and forearm is not certified.

On July 25, 2014, UR. Rationale for Denial: There is significant discrepancy between the orthopedic notes and the FCE, as well as between the FCE and the patient being at work. It is not medically likely the FCE reflects the patient's actual status given minor focal elbow sprain. This would not cause a sedentary physical demand level. Therefore, the patient's medical status does not clearly require a Chronic Pain Management Program, especially since last orthopedic evaluation 10 days after the FCE stated "significant" pain relief. Further, the patient has not exhausted all medically reasonable and/or necessary psychological treatment. No individual psychological counseling has been done. A Chronic Pain Management Program is not medically reasonable or necessary at this time.

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

DETERMINATION: denial of 10 sessions of Interdisciplinary Pain Program is OVERTURNED/DISAGREED WITH since submitted clinical information documents 10 months of chronic pain, significant functional deficits (current SEDENTARY versus HEAVY job demands), non-surgical pathology, minimal benefit from injections /12 Physical Therapy/light duty/medications including antidepressants with continued psychosocial stressors of mild-moderate severity by psychometric testing. The request for 10 sessions of Interdisciplinary Pain Rehabilitation for the left elbow/forearm at Functional Pain Center meets ODG criteria and is found to be 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)