



## Notice of Independent Review Decision

### **DATE OF REVIEW:**

12/06/2007

### **IRO CASE #:**

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

Continuation of ten (10) days of chronic pain management.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

### **REVIEW OUTCOME**

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**The requested ten additional pain management sessions are not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- MCMC: Case Report dated 11/21/07
- MCMC Referral dated 11/21/07
- DWC: Notice To MCMC, LLC Of Case Assignment dated 11/20/07 from
- DWC: Confirmation Of Receipt Of a Request For a Review dated 11/19/07
- DWC: Request For a Review By An Independent Review Organization dated 11/13/07
- Letters dated 11/26/07, 11/19/07 from
- Notice of Reconsideration Outcome-Adverse Determination dated 11/16/07
- Notice of Review Outcome: Initial Adverse Determination/Denial dated 10/16/07
- Physician Advisor Report dated 10/16/07 from, D.C.
- Prescription note dated 10/11/07
- Handwritten chart note dated 10/11/07
- Chronic Pain Management Program Patient Treatment Goals and Objectives dated 10/10/07, 06/25/07
- Chronic Pain Management Program Treatment Progress Report dated 10/08/07 from, D.C.
- DWC: Work Status Reports dated 10/05/07, 08/10/07
- Weekly Assessments dated 09/28/07, 09/14/07, 07/26/07, 07/16/07 from, D.C.
- Letter dated 09/05/07 from
- Contract of Employment signed 09/04/07
- DWC Form 150-Notice of Representation Or Withdrawal Of Representation dated 09/04/07
- Notice of Review Outcome dated 08/13/07

- Progress Notes dated 08/10/07, 07/16/07
- Physical Performance Evaluation dated 08/01/07 from, D.C.
- Follow-Up Evaluations dated 08/01/07, 06/20/07
- Chronic Pain Management Program Treatment Progress Report dated 07/30/07 from, MS, L.P.C.
- Daily Exercise Sheets dated 07/27/07 through 09/28/07
- DWC: Statement of Pharmacy Services with OK to Pay date of 07/19/07
- M.D.: Letter dated 07/12/07
- Chronic Pain Management Program Daily Group Progress Notes (handwritten) dated 07/02/07 through 09/28/07
- Pre-Authorization request dated 08/08/07
- Patient Questionnaire dated 07/25/07
- Chronic Pain Management Program Orientation Outline signed 07/02/07
- Chronic Pain Management Program Treatment Progress Reports dated 07/02/07 through 09/21/07
- Daily notes dated 07/02/07 through 09/28/07 (days of week on reports)
- Handwritten therapy notes (Cardiovascular at top) dated 07/02/07 through 07/25/07
- Undated mail label
- Undated Disability Questionnaire
- Undated Pain Questionnaire

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is a female with date of injury xx/xx/xx that led to lumbar surgery. Her diagnosis is Failed Back Surgical Syndrome (FBSS) and Myofascial Syndrome (MFS). The injured individual had twenty pain sessions as of 09/28/2007. Her gains appear to have been significant in the first ten sessions, as she was able to stop Duragesic, her Beck Depression Index/ Beck Anxiety Index (BDI/BAI) scores were reduced by almost half. However, from here forward the gains essentially stopped. Her pain scores remained 7/10, her medications remained the same (Norco, Ambien, Lexapro, soma, Seroquel) except for the fact that by the twentieth pain session her Norco was at three per day instead of four, her BDI/BAI were reduced by only two to three more points each.

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

The injured individual had twenty sessions thus far with no improvement noted after ten were done. Her pain score remained 7/10, her medications remained essentially the same with the exception that Norco went from four/day to three/day. Her BDI/BAI testing was reduced by only two to three points. Her overall improvement appears to have been in the first ten sessions as the subsequent ten did not provide many gains at all. Most pain programs are twenty sessions in length. Due to the lack of ongoing solid gains and the fact that she has had twenty already, another ten is not warranted.

#### **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:** American College of Occupational and Environmental Medicine (ACOEM) guidelines copyright 2004 pg 113-116.

## **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:**

### 1. Official Disability Guidelines (ODG) 2007:

Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the “gold-standard” content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition.

([Flor, 1992](#)) ([Gallagher, 1999](#)) ([Guzman, 2001](#)) ([Gross, 2005](#)) ([Sullivan, 2005](#)) ([Dysvik, 2005](#)) ([Airaksinen, 2006](#)) ([Schonstein, 2003](#)) ([Sanders, 2005](#)) ([Patrick, 2004](#)) ([Buchner, 2006](#))

Unfortunately, being a claimant may be a predictor of poor long-term outcomes. ([Robinson, 2004](#)) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. ([Gatchel, 2005](#)) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. ([Karjalainen, 2003](#))

**Types of programs:** There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways ([Stanos, 2006](#)):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)

(b) Multidisciplinary pain clinics

(c) Pain clinics

(d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See [Functional restoration programs](#).

**Types of treatment:** Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and

supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

**Predictors of success and failure:** As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. ([Gatchel, 2006](#)) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. ([Linton, 2001](#)) ([Bendix, 1998](#)) ([McGeary, 2006](#)) ([McGeary, 2004](#)) ([Gatchel2, 2005](#)) See also [Chronic pain programs, early intervention](#); [Chronic pain programs, intensity](#); [Chronic pain programs, opioids](#); and [Functional restoration programs](#).

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

(1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) 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; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted; (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Total treatment duration should generally not exceed 20 sessions. (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The patient should be at MMI at the conclusion.

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.

(BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs.

## 2. Official Disability Guidelines 2007:

Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see [Chronic pain programs](#)), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. ([Bendix, 1998](#)) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. ([Guzman 2001](#)) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. ([Airaksinen, 2006](#)) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. ([Karjalainen, 2003](#)) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see [Chronic pain programs](#).