



DATE OF REVIEW:

10/02/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management program for twenty days/sessions.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, and 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.

Chronic Pain Management program for twenty days/sessions is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MCMC: Case Report dated 09/21/07
- MCMC Referral dated 09/21/07
- DWC: Notice To MCMC, LLC Of Case Assignment dated 09/21/07
- DWC: Notice To Utilization Review Agency of Assignment dated 09/21/07 from
- DWC: Notice of Assignment of Independent Review Organization dated 09/21/07 from
- Center: Letter dated 09/21/07 from
- DWC: Confirmation Of Receipt Of a Request For a Review dated 09/20/07
- LHL009: Request For a Review By An Independent Review Organization dated 09/19/07
- M.D.: Memo dated 09/19/07
- Preauthorization Review Summaries dated 09/19/07, 08/27/07 from, RN
- Center: Program Preauthorization Requests dated 09/17/07, 08/21/07
- Center: Reports dated 09/17/07, 08/21/07 from, MS
- M.D.: Review dated 08/27/07
- Center: Plan & Goals of Treatment dated 08/16/07 from, MS
- P.T.: Functional Capacity Evaluation dated 08/14/07
- Center: Referral form dated 08/14/07
- Center: Consultation dated 08/15/06 from, LPC
- The System: FCE Detailed Narrative Report dated 08/14/07, , P.T.
- Center: Letter dated 08/14/07 from, P.T.
- Imaging: MRI right wrist and hand dated 08/11/06
- Dr., Pain Management dated 08/08/07
- M.D.: Letter dated 07/16/07

- Form-89: Report of Medical Evaluation with Date of Certification 07/16/07
- Follow up notes dated 01/18/07, 11/06/06
- Patient Information Sheet, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a female with date of injury xx/xx/xx. The injured individual had an injury to her right wrist when a five pound piece of glass fell on it. She ultimately had a DeQuervain release and then a right thumb arthroplasty. She had physical therapy (PT), psychiatry, work hardening, and is on multiple medications. She was evaluated for a chronic pain program in 08/2007 with the erroneous statement that she had a cervical fusion. Her Beck Depression Index (BDI) was 24, Beck Anxiety Index (BAI) was 18, her pain score was 7/10, Functional Capacity Exam (FCE) showed a sedentary capacity with a need for light/medium capacity with 78% validity in testing. A chronic pain program is requested.

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

The injured individual is a female with date of injury xx/xx/xx. The injured individual had an injury to her right wrist and ultimately had a DeQuervain release and then a right thumb arthroplasty. Postoperatively she had PT, psychiatry, work hardening, and is taking MS, tramadol, Xanax, Elavil, Ambien, Mobic, and Robaxin. She was evaluated for a chronic pain program in 08/2007. Her BDI was 24 and BAI was 18 after psychotherapy. Her pain score was 7/10, FCE showed a sedentary capacity with a job requiring light/medium capacity with 78% validity in testing. The pain program was denied multiple times due to the fact that she has had multiple treatment with no result and the etiology of her pain has not been explained. In this review, the pain program is also denied as the injured individual had questionable validity on her FCE testing and the result of sedentary is in fact questioned as the injury was to her right wrist, not her entire body. Also, the injured individual has had multiple pain program modalities with no result.

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 copyright 2004 pg 113-116.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:

Official Disability Guideline 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 therapy (and possibly chiropractic); (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) (Gatchel, 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; (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 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.

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.