



**DATE OF REVIEW:**

09/24/2007

**IRO CASE #:**

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

Chronic Pain Management (97499) for dates of service 08/01/2007-08/14/2007.

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

Doctor of Osteopathy, Board Certified In Anesthesiology, 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 (97499) for dates of service 08/01/2007-08/14/2007 is not medically necessary.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- MCMC: Case Report dated 09/10/07
- MCMC Referral dated 09/10/07
- DWC: Notice to MCMC, LLC of Case Assignment dated 09/10/07
- DWC: Confirmation Of Receipt Of a Request For a Review dated 09/07/07
- LHL009: Request For a Review By An Independent Review Organization dated 08/24/07
- Services: Reconsideration Preauthorization Report dated 08/14/07
- Services: Letter dated 08/14/07 from D.O.
- Centers: Reconsideration Pre-Authorization Request dated 08/06/07 from M.D.
- Services: Preauthorization Report dated 08/01/07
- Services: Letter dated 08/01/07
- Pain Management: Pre-Authorization Request dated 07/25/07 from M.D.
- Centers: Subsequent Medical Reports dated 07/06/07, 06/06/07, 04/04/07, 03/30/07, 02/23/07, 02/22/07, 01/03/07 from M.D.
- Centers: Mental Health Evaluation dated 06/27/07 from M.Ed., L.P.C.
- Services: Pain Management Follow-Up Evaluations dated 06/26/07, 05/01/07, 03/06/07, 02/06/07 from M.D.
- Associates: Letter dated 06/12/07 from M.D.
- Clinic: Functional Capacity Evaluation dated 02/21/07
- Associates: Neurological Consultation/EMG-NCV dated 02/09/07 (first page only)
- Services: Pain Management Initial Evaluation dated 01/09/07 from M.D.
- Centers: Subsequent Medical Report dated 01/03/07 from M.D.
- Imaging: MRI lumbar spine dated 12/16/06, lumbar spine radiographs dated 12/16/06

- Centers: Progress Assessment dated 12/07/06 from M.D.
- Centers: Initial Medical Report from M.D.
- Surgery Center: Operative Report (date and report not legible)
- Surgery Center: Letter (date and contents of letter not legible) from M.D.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is a male with date of injury. The injured individual has low back pain with no radiculopathy. MRI showed facet hypertrophy and herniation of nucleus pulposus (HNP) L4-S1. The injured individual had two caudals with excellent but short-term relief but no facet injections. He is taking naproxen, Flexeril, and Vicodin. His attending provider's (AP's) notes are contradictory with a return to work (RTW) claim in 06/2007, a statement that he is doing well at about this same time, a statement that he had psychiatric therapy and psychiatric medications but no proof of this, a denial of need for a pain program based on an 08/01/2007 review and a letter of appeal dated 08/06. Overall, there is little to no support for a pain program for this injured individual.

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

The requested pain program is denied for multiple reasons. First, the injured individual has had only epidural steroid injections (ESIs) but also has facet symptoms and this has not been addressed. Second, the injured individual has not exhausted lower levels of care such as work hardening. His Functional Capacity Exam (FCE) noted he is at sedentary and his job requires medium ability. There is a claim he had psychiatric therapy and is on psychiatric medications but there is absolutely no documentation of either of these treatments being done. Third, the notes are completely contradictory. Dr. states the injured individual can RTW after his FCE yet the injured individual had a pain program evaluation one day later. A review of 08/01/2007 states Dr. did not request a pain program for this injured individual, yet Dr. wrote a letter of necessity arguing against the denial on 08/06. The note of 06/26/2007 states the injured individual's pain is 3/10 on his new medication (naproxen) yet the pain program evaluation done the next day notes his pain is 9/10. The injured individual is only taking naproxen, Flexeril, and Vicodin as needed (PRN). There is clearly room to expand his medications. Dr. alludes to a Designated Doctor Evaluation (DDE) but this is not presented. Finally, this injured individual is old. The overall job market for him is minimal at best therefore a pain program with promise of return to work may be unnecessary. For all these reasons, the pain program is denied.

## **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

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

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. 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; (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.