

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

08/11/2008

### **IRO CASE #:**

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

Chronic Pain Management Program twenty sessions

### **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 20 session Chronic Pain Management Program is not medically necessary.**

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

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 08/06/08 Request For Medical Dispute Resolution, , Ph.D.,
- 07/25/08 MCMC Referral
- 07/24/08 Notice To MCMC, LLC Of Case Assignment, , DWC
- 07/23/08 Confirmation Of Receipt Of A Request For A Review, DWC
- 07/02/08 Request For Reconsideration, D.C.,
- 07/15/08 Request For A Review By An Independent Review Organization
- 07/15/08 Reconsideration Preauthorization Report, Medical Business Management Services
- 07/01/08 office note, Insight Medical Diagnostics
- 07/01/08 Functional Capacity Evaluation Summary, Medical
- 06/23/08 Pre-Authorization Report, Medical Business Management Services
- 05/16/08 Initial Interview, , PhD,
- 05/16/08 Indication of Evaluation,
- 09/17/07 Operative Report, , M.D., Hospital
- 08/30/07 MRI left knee, Diagnostic Imaging
- 07/13/07 Preliminary MRI lumbar spine, Medical Imaging
- 11/21/06 report from Medical Diagnostics
- 09/08/06 report from Medical Diagnostics

- 05/11/06 Operative Report, M.D., Foundation Center
- Undated Treatment Plan
- Note: Carrier did not supply ODG Guidelines.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual has mixed injuries and dates reported (either xx/xx/xx or xx/xx/xx and either ankle and knee or low back). One review states his date of injury is xx/xx/xx when he injured his right ankle and knee yet he had left knee surgery in 09/2007. The physician pain evaluation states his date of injury was xx/xx/xx and was to his low back, leading to a L5 hemilaminectomy in 2006. The injured individual returned to work in 02/2008 but was unable to perform as a custodian so he stopped. He is on Naprosyn, hydrocodone, and Flexeril. His Functional Capacity Evaluation (FCE) of 07/2008 showed he is performing at light duty and needs heavy. His pain evaluation of 05/2008 showed Beck Depression Index (BDI) of 22, Beck Anxiety Index (BAI) of 31.

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

The injured individual has mixed injuries and dates reported. One review states his date of injury is xx/xx/xx when he injured his right ankle and knee yet he had left knee surgery in 09/2007. The physician pain evaluation states his date of injury was xx/xx/xx and was to his low back, leading to a L5 hemilaminectomy in 2006. The injured individual returned to work in 02/2008 but was unable to perform as a xx so he stopped. He is on Naprosyn, hydrocodone, and Flexeril. His FCE of 07/2008 showed he is performing at light duty and needs heavy. His pain evaluation indicated he had moderate levels of depression and anxiety. The pain program is denied for numerous reasons. First, the dates of injury and the injuries themselves are not matching. Second, the injured individual has had no postoperative treatment such as psychiatric medications, physical therapy (PT), work hardening/conditioning, or psychotherapy documented. Finally if a pain program is suggested, typically an initial ten sessions are recommended to monitor for injured individual compliance and progress. A pain program is an end stage treatment option when other therapies have failed. There is no indication this injured individual has done any lower levels of care.

**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 pg 113-116**

**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 (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) (Gatchel, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower

grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of *Spine*. (Buchner, 2007) 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 full-day 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 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. 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.