I-Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, Maine 04915
(512) 782-4415 (phone)
(512) 233-5110 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Sessions

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

MD, Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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 reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 10 Sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/7/08, 7/21/08
Official Disability Guidelines Treatment in Worker's Comp 2008, Pain
Office notes, Dr., 09/29/07, 03/01/08, 03/29/08, 07/02/08, 09/08/07, 11/30/07, 12/03/07, 02/16/08, 05/27/08
Beck Depression Inventory, 09/13/07
LPC, 09/13/07
MRI lumbar spine, 09/25/07
MRI cervical spine, 09/25/07
H&P, Dr. , 01/19/08

Office note, Dr., 03/21/08
EMG/NCV, 03/27/08
FCE, 06/27/08
Request for additional 10 days, 06/27/08
Office note, , 07/01/08
Office note, Dr., 07/16/08, 07/07/08, 07/18/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female injured on xx/xx/xx when she was trying to hold hinged doors open and developed neck pain, back pain, and pain in both arms and legs.

On 09/08/07 Dr. saw the claimant. On examination there was spasm of the cervical and lumbar spine with decreased motion; decreased reflexes and numbness and dysesthesia in the arms and decreased pinprick sensation. There was also positive straight leg raise. The impression was lumbar disc, bilateral lumbar radiculopathy, cervical displaced disc, bilateral cervical radiculopathy, thoracic sprain/strain and intractable headache. He recommended therapy and MRI scans.

The 09/25/07 MRI of the lumbar spine showed a T10-11 central protrusion with effacement of the thecal sac. There were L3-4 protrusions with mild effacement of the anterior thecal sac. At L4-5 mild disc bulge with moderate degenerative facet change and ligamentum flavum hypertrophy; moderate lateral recess narrowing; and mild bilateral foraminal narrowing. At L5-S1 there was desiccation and disc space narrowing; mild effacement of the thecal sac; mild degenerative facet change and ligamentum flavum hypertrophy. On 09/25/07 an MRI of the cervical spine showed C5-6 disc space narrowing and a small bulge with osteophytes, uncovertebral spurring and bilateral foraminal narrowing. There was C4-5 disc space narrowing; osteophyte that contacted and possibly slightly indented the cord; bilateral foraminal narrowing; and uncovertebral spurring.

In 11/07 Dr. noted that the claimant was in therapy. Her examination remained unchanged. Therapy ended in 12/07 and work hardening was recommended.

On a 02/16/08 visit Dr. indicated that the claimant was taking Naprosyn daily and Darvocet 1-2 every 6 hours. EMG studies were done of the upper extremities on 03/27/08 and reported as normal. The claimant completed 20 sessions of work hardening and pain management program according to the 05/27/08 note. An FCE on 06/27/08 indicated the claimant tested at a light to medium level.

Additional pain management was recommended for 10 sessions. This was denied on two occasions. On 07/16/08 Dr. appealed the denial noting that the goal of the program was not to eliminate pain but improve function and reduce stress. She noted that the claimant had made steady progress and was close to achieving a medium PDL. It was felt that 10 days would allow her to reach that goal. She had reduced Darvocet to 1 a day and was less frustrated and irritable. Her age and comorbid conditions were felt to break her out of the ODG mold. She had a diagnosis of chronic pain syndrome, she was felt likely to show improvement in 3 of the 7 program goals; and that this was the treatment of choice to promote recovery.

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

This is a xx-year-old woman who reports chronic pain associated with holding up hinged doors on xx/xx/xx. She has been treated with 20 sessions of pain management with pain levels unchanged, 20 sessions of work hardening, 9 sessions of psychotherapy and 10 sessions of physical therapy. Based on her failure to respond to prior conservative measures, the reviewer cannot recommend as medically reasonable and necessary at this juncture an additional multidisciplinary pain management program. The claimant has already met or exceeded ODG guidelines which recommends 20 full-day sessions. This is based on review of the records provided and consistent with ODG guidelines. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 10 Sessions.

Official Disability Guidelines Treatment in Worker's Comp 2008, Pain
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) 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.

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)