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DATE OF REVIEW: 01/31/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Behavioral Pain Management Program - 10 Sessions

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

This case was reviewed by a Texas licensed MD, specializing in Physical Medicine & Rehabilitation. The physician advisor has the following additional qualifications, if applicable:

ABEM, ABMS Electrodiagnostic Medicine, Physical Medicine & Rehabilitation
 TX DWC ADL

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Chronic Behavioral Pain Management Program - 10 Sessions	97799	N/A	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Work Hardening Progress Note	Injury Center	9	06.26.07	07.13.07
2	Rehab Eval	Rehab	9	07.30.07	07.30.07
3	Office Visit Report	Injury Center/ DC	3	10.22.07	10.22.07
4	FCE Exam	DC	5	11.13.07	11.13.07
5	Office Visit Report	MA, LPC	5	11.13.07	11.13.07
6	Pre-Cert Request		5	11.17.07	11.17.07
7	Initial Denial Letter		3	11.28.07	11.28.07

8	Work Hardening Pre-Auth Request	Injury Center/ DC	4	11.30.07	11.30.07
9	Appeal Request		3	12.07.07	12.07.07
10	Appeal Denial Letter		4	12.20.07	12.20.07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx-year-old male with a date of injury of xx/xx/xx, and reports a lumbar injury from “heavy lifting”. The claimant was treated with rest, medications, physical therapy, injections and chiropractic treatment. There is mention of a lumbar surgery on 02/19/2007. The claimant received 22 sessions of post-operative physical therapy and 10 sessions of work hardening.

On 11/28/2007, the request for 10 sessions of Chronic Pain Management Program was denied, stating “based on the clinical information submitted for this review and using the Evidence-Based, Peer-Reviewed guidelines referenced above, this request” was not considered medically necessary.

On 12/20/2007, the reconsideration was denied and the reviewer opined, “The main purpose of these programs is to return a patient back to some form of vocation and to wean a patient off sedative medications so a patient can do this. There are no documented vocation goals concerning what the patient wants to do after the program. The ODG guidelines does not come out and full endorse these programs unless where there is access to programs with proven successful outcomes. This program is not CARF certified and there is no documentation showing there percentage of patients that have returned to work.”

The disputed service is Chronic Pain Management program - 10 sessions

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

In my opinion, the request for 10 sessions of the Chronic Pain Management program does not fall within the Evidence-Based, Medical Guidelines. I agree with the previous denial that there is a lack of documentation of vocational goals and the psychological assessment reported only “mild” deficits, without identifying the medical necessity of this request. This claimant’s care has exceeded the typical timeframes, for others with similar injuries.

In my opinion, the denial should be upheld.

Chronic pain programs: Recommended where there is access to programs with proven successful outcomes. 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) (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.
- (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.

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 admissions for chronic pain may be considered medically necessary when there are significant medical and/or psychiatric comorbidities, case complexity requiring multiple consultants, implantation trials, and/or significant pain behavior and reported dysfunction that require 24/7 observation and treatment (this should be considered on a case by case basis with written justification). (BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs.

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

ODG:

Integrated Treatment/Disability Duration Guidelines / Pain (Chronic) /Chronic pain programs

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To

contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 01/31/2008.