

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

09/08/2008

### **IRO CASE #:**

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

Multidisciplinary chronic pain management program five times per week for eight hours per day for two weeks consisting of forty hours.

### **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.

**Multidisciplinary chronic pain management program five times per week for eight hours per day for two weeks consisting of forty hours is not medically necessary.**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The injured individual is a xx year old female with date of injury xx/xx. The injured individual fell on a wet floor. The MRI showed a minimal 2mm protrusion at L5. The injured individual had fifteen pain sessions in 05/2007. Her pain went from a 6 to a 4. She had five more pain sessions in 10/2007 and ten more in 02/2008. In 03/2007 her pain was still 4/10. She was on hydrocodone 7.5 at a rate of 0-4/day; in the past she was on 10mg at 0-4/day. She had discontinued the Soma but was on Flexeril, Xanax, and Prozac. Her Beck Depression Index (BDI) was 27; it had been 38 reportedly although this is not documented. Her BDI as of 06/04/2008 was 24. Her Beck Anxiety Index (BAI) as of 03/2008 was 4; it had been 42 although documentation of this is not available. Her BAI of 06/2008 was 21.

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

This injured individual had minimal findings on physical exam (PE) and MRI. The injured individual had 30 pain sessions overall even though they were truncated. The injured individual was on hydrocodone 7.5 in the past and is now on 10mg. Both doses were at a rate of 0-4 per day as needed. The BDI is now 24; it was 38 initially and then 27 before the last ten pain sessions. The BAI is now 21; it was 42 then 6 after the last ten pain sessions. The injured individual is now on Prozac, Flexeril, Xanax and hydrocodone. She is touting the fact that she discontinued the Soma but she is now on Flexeril and Xanax which she was not on before as well as a relatively similar dose of hydrocodone. Her overall improvement has been minimal. Her medication reliance is the same or

more intensive, her psychiatric profile is at least as strong or worse, her complaints and lack of function are the same or worse. After 30 pain sessions, more pain management is not warranted in this situation. Thirty sessions of a pain program is more than sufficient per Official Disability Guidelines and the literature. This injured individual has made minimal to no improvement with this treatment. Continuing it is not recommended.

**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 2004 pg 113-116.**

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

Official Disability Guidelines 2008: 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. However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. 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.