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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pain Management 5 times per week times 2 weeks (97799) 10 total units

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/29/09, 2/11/09
Spinal Rehab Center, 2/24/09, 2/4/09, 12/31/08, 1/15/09
FCE, 2/16/09
MD, 2/4/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured xx-xx-xx while lifting and carrying sacks. He developed neck and low back pain. Physician notes described degenerative changes in the cervical and lumbar region without evidence of any nerve root compression. An EMG was done and although reported as normal, one physician stated it was incomplete due to pain. The different doctors described him to be highly anxious with pain behaviors and symptom magnification. His Oswestry, Neck Disability, McGill and Dallas Pain scores showed high-perceived disability. The Positive Waddell signs document a significant nonorganic component of his pain. He was unable to complete an FCE on 1/15/09 due to his pain and symptom magnification. Dr. performed a Designated Doctor Examination on 2/4/09 and described significant psychological issues affecting his pain. Dr. description stated that his anxiety and depression are not being treated. He became desperate during his FCE and this lead to the suboptimal study.

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

The progress note of 2/4/09 described the need for addressing both this patient's deconditioned state and the pain behaviors he was demonstrating. The authors of the note did not feel any single modality alone would suffice and a comprehensive pain program would be more appropriate. Chronic pain programs are designed for patients "at risk of delayed recovery." The ODG selection criteria presumes patient motivation, although the predictor section describes higher failure rates with psychosocial distress. He has symptoms of depression, pain and perceived disability with largely intractable pain in the reports reviewed. The ODG also encourages early intervention. This man is now 6 months post injury. He appears to meet the criteria highlighted for participation in the program. The ODG does allow patients into chronic pain programs up to 2 years post injury. The records indicate further delay could lead to more ingrained perceptions of his disability rather than demonstrating to him his ability to work. The patient meets the guidelines for CPMP x 10 sessions. The reviewer finds that medical necessity exists for Pain Management 5 times per week times 2 weeks (97799) 10 total units.

Chronic pain programs (functional restoration programs)

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), 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 & occupational 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) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders....

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)

Timing of use: Early intervention is recommended (3 to 6 months post-injury) depending on identification of patients that may benefit from early intervention via a multidisciplinary approach. See Chronic pain programs, early intervention. The probability of returning to work for those out over two years may be less than 1%, if such patients are not offered quality, comprehensive interdisciplinary functional restoration programming. In a high-quality cohort study, the short-term disabled group (4-8 months post-injury) achieved statistically higher RTW compared to the long-term disabled group (> 18 months post-injury), suggesting that early use of a functional restoration program is efficacious, but individuals with long-term disability still achieved respectable RTW justifying use of the program. (Jordan, 1998) (Infante-Rivard, 1996) (TDI, 2007)

See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention

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) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component

(2) The patient has a significant loss of ability to function independently resulting from the chronic pain

(3) 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

(4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided

(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement

(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change

(7) Negative predictors of success above have been addressed

(8) These programs may be used for both short-term and long-term disabled patients. See

above for more information under Timing of use

(9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) 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. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures 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

(10) 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

(11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury.

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

ACOEM-AMERICA 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)