

Notice of Independent Review Decision

DATE OF REVIEW:

01/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten (10) sessions of Chronic Pain Management Program.

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.

Ten (10) sessions of Chronic Pain Management Program are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION Referral form
- 12/29/08 letter from ,
- 12/23/08 Referral
- 12/22/08 Notice To , LLC Of Case Assignment, , DWC
- 12/19/08 letter from ,
- 12/05/08 Request For A Review By An Independent Review Organization
- 11/10/08 Adverse Determination After Reconsideration Notice, , PhD,
- 10/24/08 Request For An Appeal, , Ed.D.,
- 10/14/08 Progress Note Week #7,
- 10/14/08 Weekly Goal Sheet,
- 10/13/08 Adverse Determination Notice, , M.D.,
- 10/08/08 Fax Cover sheet with note from
- 10/07/08 Pre-Certification Request from , Ed.D.,
- 10/07/08 Weekly Goal Sheet,
- 10/07/08 Progress Note Week #6,
- 09/30/08 Progress Note Week #5,
- 09/30/08 Weekly Goal Sheet,
- 09/22/08 Follow Up Report, , M.D.
- 09/15/08 Initial Consultation, , M.D.
- 08/25/08 Examination Findings, , D.O.,
- 08/04/08 Evaluation, , L.B.S.W.,
- Undated ODG Pain guidelines
- Undated, unsigned Confirmation Of Receipt Of A Request For A Review, DWC

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx year old female with date of injury xx/xx and lumbar fusion and hardware removal. The injured individual was on Zanaflex and hydrocodone two to four per day and Mobic before the pain program and is on the same amount of narcotic now. Her Beck Depression Index (BDI) preprogram was 10 and is now 16; Beck Anxiety Index (BAI) was 13 and is now 30. Her sleep pattern was three to four hours and now is five hours; her Physical Demand Level (PDL) was sedentary and is now light but she needs medium. Her overall progress after 20 sessions has been minimal.

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

The injured individual has already had twenty sessions which is a reasonable amount per Official Disability Guideline. She has made minimal progress as her medications have remained essentially the same, sleep patterns have minimally changed, her BDI and BAI have increased, and her function has progressed from sedentary to light only. No further pain program sessions are necessary based on the amount of sessions she has had and the minimal response she has had to these sessions.

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:

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.

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.