



5068 West Plano Parkway Suite 122
 Plano, Texas 75093
 Phone: (972) 931-5100

DATE OF REVIEW: 03/19/2009

IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPMP x 10 days

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 DC, specializing in Chiropractic. The physician advisor has the following additional qualifications, if applicable:

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 |
|-----------------------------------|-----------|--------------------|-------------------------------|
| CPMP x10 days | | | Upheld |

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

| No | Document Type | Provider or Sender | Page Count | Service Start Date | Service End Date |
|----|---------------------|-------------------------------|------------|--------------------|------------------|
| 1 | Office Visit Report | Spinal Rehabilitation Centers | 13 | 01/02/2009 | 02/24/2009 |
| 2 | Office Visit Report | Medical Center | 109 | 09/19/2007 | 12/22/2008 |
| 3 | Office Visit Report | | 8 | 09/13/2007 | 02/05/2008 |
| 4 | Diagnostic Test | Neuroscience Centers | 2 | 05/31/2007 | 05/31/2007 |
| 5 | FCE Report | Superior FCE & Associates | 7 | 02/02/2009 | 02/02/2009 |
| 6 | Diagnostic Test | | 1 | 05/25/2007 | 05/25/2007 |
| 7 | RME | Evaluations | 23 | 11/14/2007 | 01/14/2009 |
| 8 | Peer Review Report | | 6 | 04/02/2008 | 04/02/2008 |
| 9 | PT Notes | | 94 | 06/04/2007 | 02/19/2009 |
| 10 | Op Report | Hospital | 7 | 06/15/2005 | 01/11/2008 |
| 11 | Approval Letter | | 9 | 08/29/2007 | 01/21/2009 |

| | | | | | |
|----|----------------------------------|-------------------------------|----|------------|------------|
| 12 | Initial and Appeal Denial Letter | | 23 | 10/10/2007 | 02/11/2009 |
| 13 | Archive | | 1 | 01/02/2008 | 01/02/2008 |
| 14 | IRO Request | Texas Department of Insurance | 13 | 02/27/2009 | 02/27/2009 |
| 15 | DME Request | DME | 5 | 08/22/2007 | 08/14/2008 |
| 18 | TWC Work Status Report | MD | 2 | 08/07/2008 | 12/22/2008 |

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the submitted data, this claimant is a female who reported she injured her left elbow from chronically lifting boxes of files and paperwork over the years. The date of injury is documented on xx/xx/xx. The claimant sought care with Dr. on 05/07/07 who examined her and began treatment with conservative chiropractic care. On 05/25/07 an MRI of the left elbow was performed and found to be negative. On 05/31/07, an EMG/NCV of the upper extremities were performed and significant findings were noted including left motor ulnar neuropathy, left CTS, left sensory ulnar and radial neuropathy. The claimant was then referred to pain management and received 5 injections without resolving her complaints. On 12/06/07, the claimant was sent to a Designated Doctors Examination with Dr. who certified her at clinical MMI on 12/06/07 with a calculated 1% whole person impairment. However on 01/11/08, the claimant's case continued with approval for surgery for a fasciotomy, debridement and tenosynovectomy of the left elbow by Dr. On 02/20/08, the claimant was again sent back to Dr. who then overturned her previous MMI data and impairment rating to not achieving MMI. The claimant continued with post-operative physical therapy. On 07/17/08, Dr. indicated the claimant was post-operative from her second surgical procedure of the cubital tunnel release of the left elbow. The claimant again continued complaining of chronic pain and was recommended to continue the post-operative physical therapy. On 09/25/08, the claimant stated that the post-operative therapy made her condition worse. On 10/30/08, Dr. re-examined and indicated he had exhausted all that he could offer the claimant. The claimant was then referred to yet another physician who suggested a possible RSD diagnosis. On 01/02/09, the claimant was sent to Dr. (psychologist) who subsequently treated with individual psychotherapy sessions 6 times. On 01/08/09, the claimant was yet again sent back to Dr (DDE) who again indicated she was not at MMI. On 02/02/09, an FCE was performed which indicated the claimant was at a sedentary PDL with her occupational PDL being light. On 02/03/09, Dr. examined her and recommended a chronic pain management program. Now, Dr. is requesting 10 sessions of chronic pain management.

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

As noted and cited in the above section of this report there are several variable that have been found to be negative predictors of the efficacy of treatment with the programs as well as the 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. It is apparent the claimant does not only have a few, but she has all of the predictors that she would be a poor candidate for the program.

Furthermore, the timing of the request for the CPMP is also a negative predictor in this case. The claimant's claim is almost 2 years old and appears the surgical intervention did not help the condition but made it worse from the claimant's functional as well as subjective complaints. The guides also state the times of entering the program should be 3-6 months post-injury which this claimant clearly exceeded that recommendation.

Therefore, the request for 10 sessions of chronic pain management program is not considered medically necessary, reasonable nor supported by the guides as cited above.

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 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](#))

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.

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](#).

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

ODG: pain, procedure summary, chronic pain management programs