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Notice of Independent Review Decision

DATE OF REVIEW:
05/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Ten 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 additional pain sessions are not indicated.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 05/06/10 letter from Flahive, Ogden & Latson (first page only)
- 05/04/10 MCMC Referral
- 05/03/10 Notice To MCMC, LLC Of Case Assignment DWC
- 04/30/10 letter from Steven Tipton, Flahive, Ogden & Latson
- 04/30/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 04/28/10 Request For A Review By An Independent Review Organization
- 04/12/10 Adverse Determination After Reconsideration Notice, M.D., Zurich Services Corporation
- 04/05/10 Request For Reconsideration letter, M.D., Clinic
- 03/19/10 Adverse Determination Notice, M.D., Zurich Services Corporation
- 03/16/10, 04/06/10 Request For Preauthorization, Concurrent Review, and Voluntary Certification, Pain & Recovery Clinic
- 03/08/10, 11/28/10 reports from BSW and PsyD, Clinic
- 01/11/10 Progress Summary, BSW and PsyD, Clinic
- 12/18/09 Pre-Authorization Request, M.D., Clinic
- 12/10/09 Mental Health Evaluation, Ed., and M.D.
- 12/10/09 Work Capacity Evaluation, Functional Testing

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- ODG Integrated Treatment/Disability Duration Guidelines for Pain (Chronic)

PATIENT CLINICAL HISTORY [SUMMARY]:
The injured individual has had twenty pain sessions. She began in 12/09 with a pain score of 7; Beck Depression Index (BDI) of 29; Beck Anxiety Index (BAI) of 19. She was receiving Darvocet, Feldene and Cymbalta. By 01/11 the attending provider (AP) was requesting the "final" ten sessions to make a total of twenty. Her pain score was 4; BDI was 12; BAI was 9; no medications were listed. Her original Functional Capacity Exam (FCE) of 12/09 indicated she was at sedentary/light and needed medium physical demand level (PDL) but no further FCEs are done. By 3/10 after twenty visits, there are no medications or current PDL listed, her pain score is still 4; BDI is 11; BAI is 7.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The injured individual has had twenty pain sessions. She began in 12/09 with a pain score of 7; BDI of 29; BAI of 19. She was on Darvocet, Feldene and Cymbalta. By 1/11 the AP was requesting the "final" ten sessions to make a total of twenty. Her pain score was 4; BDI was 12; BAI was 9; no medications were listed. Her original FCE of 12/09 indicated she was at sedentary/light and needed medium PDL but no further FCEs are done. By 3/10 after twenty visits, there are no medications or current PDL listed; her pain score is still 4; BDI is 11; BAI is 7. Overall, there has been no progress in her pain score from pain session number ten to number twenty; there is no indication of medication reduction or PDL progress from pain session number one to number twenty; her BDI and BAI barely budged after pain session number ten. There is a plateau in her progress such that more treatment beyond twenty visits is not indicated.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:
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 in the following circumstances:
(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.
(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

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(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.
(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.
(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.
(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.
(10) 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

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continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
(12) Total treatment duration should generally not exceed 20 full-day (160 hours) 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 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
(13) At the conclusion and subsequently, neither re-enrollment in 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 (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.
(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.
(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.
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. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.