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An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW:
AUGUST 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program five times a week for two weeks for the lumbar spine

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

Board Certified Orthopedic Surgeon

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

Office note, 06/21/06 and 02/19/07

Office notes, Dr., 09/13/06k, 10/18/06, 11/15/06, 12/13/06, 01/10/07, 03/23/07, 04/11/07, 05/03/07, 05/30/07, 06/20/07, 06/27/07 and 07/20/07

Functional capacity evaluation, 06/29/07

Note, Dr. 07/12/07

Note, LCP, 07/18/07

Review, Dr. 07/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male with the diagnosis of lumbar displaced disc, bilateral lumbar radiculopathy and intractable pain. The claimant treated with Dr. for his persistent lower back pain and

radiculopathy with anti-inflammatory medications, physical therapy, off work, work hardening and Skelaxin. The claimant was reportedly seen by a neurosurgeon who had prescribed Neurontin. Dr. of chiropractics performed a lumbar decompression in November 2006. The claimant had been seen on several occasions by Dr. beginning in September 2006 and ending July 2007. Dr. noted no relief from epidural steroid injections, normal electromyography and essentially no change in the physical exam findings which were spasm, decreased range of motion of the lumbar spine in all range of motions, lumbar myospasms and myositis. The 06/29/07 functional capacity evaluation deemed the claimant capable of performing medium duty. The testing was considered to be valid. The records reflect that this claimant had completed 20 sessions of chronic pain management. Peer reviews on 07/12/07 and 07/23/07 were completed and denied additional 10 chronic pain management sessions. Mr. on 07/18/07 requested reconsideration for the 10 pain management sessions due to the claimant was still taking narcotics, anti-inflammatory medications and Effexor. Mr. noted that the claimant must be able to lift 143lbs occasionally and had not achieved that with work hardening.

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

The Reviewer agrees with the previous denial of the medical necessity for pain management in this particular individual's case for the following reasons:

While it appears as though this individual had documented improvement in functional abilities over the course of the four weeks of previous pain management, the Reviewer is somewhat surprised to see that in spite of the functional gains that this individual reportedly saw no meaningful improvement in his symptoms. This would be an inconsistency in the Reviewer's opinion to the extent that the Reviewer would normally not anticipate substantial functional improvements yet require an individual to continue to take significant pain medications. For that reason alone it is difficult to suggest that the additional two weeks of pain management (10 sessions) would be likely to demonstrate meaningful improvement following this individual's previous 20 sessions. If pain management techniques did not result in substantial pain relief and diminished pain medication requirements in the initial four weeks, the Reviewer is doubtful that they will see further improvement.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates, Pain: Chronic Pain Programs

Recommended where there is access to programs with proven successful outcomes. 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 therapy. 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. Unfortunately, being a claimant may be a predictor of poor long-term outcomes. 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. 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.

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.

(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 **Types of treatment**: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical therapy (and possibly chiropractic); (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. 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.

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.

(2) Previous methods of treating the chronic pain have been unsuccessful.

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

(3) The patient is not a candidate where surgery 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.

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.

Inpatient admissions for pain rehabilitation may be considered medically necessary only if there are significant medical complications meeting medical necessity criteria for acute inpatient hospitalization

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
- 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)