

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW: 12/02/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5x4

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

Clinical psychologist; Member American Academy of 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

03-21-07 Office note from MD
07-10-07 Office note from MD
03-19-07 Cervical and Lumbar MRI reports; Open MRI
04-23-07 Initial H&P and eval for lumbar ESI's; MD
05-02-07 Procedure note for lumbar ESI L5/S1; MD
05-30-07 Designated Doctor Exam pgs. 1-5/11 ; MD
09-06-07 Office note; MD
09-19-07 Initial psychological CPMP evaluation; author unknown
10-29-07 Initial denial letter; PhD
10-3-07 Request for reconsideration; DC
11-21-07 Request for MDR; PhD

No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured performing his job duties as a when he was injured. Records indicate he was pushing pipes into the spinning wheels to be grinded when somebody twisted the pipe behind him before he was clear, causing him to be pushed between two pipes. Patient went to the ER, where x-rays were administered which were negative for fracture. Patient was provided meds and observed overnight before being released.

On follow-up exam, patient was diagnosed with neck pain and lumbar pain via patient subjective reports, was placed in a cervical collar, and referred to the ER to rule out kidney laceration, which was ruled out. Records indicate that CT scan of the kidneys was negative, and bladder and/or renal injury were also ruled out.

Patient began treating with Dr. on 02-07-07. Patient was prescribed Naproxen, Darvocet, and Zanaflex, was planned for physical therapy 3x2, and referred for diagnostics. MRI of the lumbar spine done on 3-19-07 showed a congenitally narrowed spine, but was otherwise unremarkable. MRI of the cervical spine done on the same day showed changes of spondylosis throughout the cervical spine as described above, most pronounced at C3-C4 where there is moderate canal stenosis, cord compression, and myelomalacia.

On 04-23-07, patient was evaluated by Dr. for lumbar epidural steroid injection L5-S1, which was given on 5-2-07. Dr. gives the patient diagnoses to include lumbar HNP, although this is not substantiated on the lumbar MRI available for review. He additionally refers the patient to a spine surgeon for evaluation of his cervical spine. No notes regarding surgery are submitted for review, but records indicate that patient did at some time receive a spinal cord stimulator. It is unknown whether or not any other surgery was received.

On 5-30-07, patient was seen by a designated doctor, who assigned MMI and IR. On 7-10-07, Dr. sees the patient and patient was given diagnoses of lumbago and cervicgia, and prescribed Naprosen, Zanaflex, and Ultram ER, was referred for pain medication management only, and was scheduled to RTC in a month.

On 09-06-07, patient is seen by Dr. who states on his report that patient has run out of his meds from Dr. and patient "states he really needs his pain medications." Dr. stated in summary that "Examination of the lumbar spine is perfectly normal apart from the fact the patient has a lot of positive Waddell signs. Neurologic exam of the lower extremities is normal. cursory examination of the cervical spine is essentially unremarkable. The patient's gait is normal. Patient is prescribed Ultram, Celebrex, and Zanaflex, and Dr. makes a referral to

PhD “for numerous behavioral issues which seem to be at work here.” He further states, “I do not intend to give the patient any opioid-containing medications. There are too many red flags here and too many unanswered questions. After Dr. s’ evaluation, I think I will get a much better understanding of exactly the issues...”.

On 10-02-07, patient was evaluated for a chronic pain management program. Patient reported his average pain level at 8/10, and reported that this has not changed in the past year (even with medications) and is usually present 100% of the time. Present coping strategies for pain were not reported. BDI was 28 and BAI was 40. SOAPP score was 19, indicating high risk for potential abuse of narcotic pain meds. Report states that patient believed he received counseling at US Healthworks, with no reduction in his depression or pain levels, although there are no records to substantiate this. Patient also states he received no relief for his back pain with the physical therapy.

Mental status showed a patient who was oriented x 3, was indifferent, and evidenced affect appropriate to content. Some of the indications for the program were that patient had chronic pain linked to adverse interpersonal relationships, continues to express unrealistic expectations regarding outcome, and was judged to be at high risk for development of an excessively disabled lifestyle, although there is no testing to substantiate these. Goals for the program were to allow patient to start with small goals that would help him feel more hopeful, and after experiencing some success, he would be motivated to advance to bigger goals.

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

Although the psychological report states that the expected clinical response and prognosis for returning to work is good, it does not assess contraindications such as patient’s inability to benefit in any way from previous counseling, continued high pain reports despite medications, inability to benefit at all from physical therapy, reported unrealistic expectations, and failure to return to higher levels of productivity after implantation of a spinal cord stimulator. In fact, this aspect of care was never mentioned in the patient history. The question of why antidepressant medication was never considered is also not addressed. In addition, baseline functional testing is not done, which is a criteria for admission to such a program.

The report also does not appropriately address the recent referral question from Dr. with regard to patient inorganic pain complaints and possible motivations. Whether or not the pain is purely psychogenic in origin has to be ruled out before appropriate treatment plans can proceed. It would seem that testing to assess personality and/or to rule out malingering should have been accomplished prior to requesting a pain program. Additionally, given the mental status exam, it is

difficult to see how a diagnosis of MDD was reached, other than patient's subjective report on a BDI, which obviously needs to be established in a more objective way. With all of these mitigating factors present, medical necessity cannot be established for these requested services. (See ODG Pain section; See also the following pertinent study by *McGeary DD, Mayer TG, Gatchel RJ. High pain ratings predict treatment failure for occupational musculoskeletal disorders. J Bone Joint Surg Am. 2006 Feb;88(2):317-25; and Aetna admittance criteria*)

Productive Rehabilitation Institute of Dallas for Ergonomics (PRIDE) Research Foundation, 5701 Maple Avenue, Dallas, TX 75235, USA.

BACKGROUND: Pain intensity is one of the most widely used measures in the treatment of patients with chronic disabling occupational musculoskeletal disorders. Few studies have comprehensively investigated the relationship of pain intensity at the time of rehabilitation to objective socioeconomic outcomes at one year after treatment. This study evaluated the ability of pain intensity ratings, measured with a visual analog scale, to predict rehabilitation outcomes and to identify patients who are "at risk" for a poor outcome. **METHODS:** A cohort of 3106 patients with chronic disabling occupational musculoskeletal disorders in a multidisciplinary occupational tertiary rehabilitation program was divided into four groups on the basis of the pain intensity ratings (0 to 3, 4 to 5, 6 to 7, and 8 to 10) before and after rehabilitation. A structured interview to assess the socioeconomic outcomes, including work status, health-care utilization, recurrent injury, and whether there had been resolution of Workers' Compensation or third-party financial disputes, was conducted one year after rehabilitation. **RESULTS:** High pain intensity before rehabilitation was linearly associated with declining rates of program completion and higher rates of self-reported depression and disability after rehabilitation. Although higher pain ratings both before and after rehabilitation were associated linearly with a declining quality of socioeconomic outcomes, extremely high pain ratings (8 to 10) after rehabilitation were most predictive of poor outcomes. At the post-rehabilitation evaluation, patients with extreme pain were far more likely than those with mild pain to seek surgical treatment (risk ratio = 11.2 [95% confidence interval, 4.3, 29.5]) or to persist in seeking health care from new providers (risk ratio = 3.3 [95% confidence interval, 2.4, 4.5]). They were less likely to either return to work (risk ratio = 3.9 [95% confidence interval, 2.6, 6.0]) or to retain work (risk ratio = 4.2 [95% confidence interval, 2.9, 6.0]). They were also twice as likely to claim a new injury to the same musculoskeletal site after returning to work and to fail to settle Workers' Compensation or third-party financial disputes. **CONCLUSIONS:** High pain ratings before rehabilitation are associated with higher rehabilitation dropout rates. The patients with chronic disabling occupational musculoskeletal disorders who reported extreme pain after completing a full course of extended treatment (13% of 2573) were at risk for poor outcomes in terms of lost productivity, high utilization of health care, and cost-shifting of state Workers' Compensation payments to federal resources.

Aetna Clinical Policy Bulletins. Chronic Pain Programs Number 0237. Reviewed: May 5, 2006.

Aetna considers a screening examination medically necessary for members who are being considered for admission into a chronic pain program.

1. Outpatient Pain Management Programs

Aetna considers outpatient multidisciplinary pain management programs medically necessary when all of the following criteria are met:

- * Referral for entry has been made by the primary care physician/attending physician; and
- * Member has experienced chronic non-malignant pain (not cancer pain) for 6 months or more; and
- * The cause of the member's pain is unknown or attributable to a physical cause, i.e., not purely psychogenic in origin; and
- * Member has failed conventional methods of treatment; and
- * The member has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated; and
- * Member's work or lifestyle has been significantly impaired due to chronic pain; and

* If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into the pain program.

Aetna considers entry into an outpatient multidisciplinary chronic pain program not medically necessary for members with any of the following contraindications:

- * The member is unable to understand and carry out instructions; or
- * The member exhibits aggressive and/or violent behavior; or
- * The member exhibits imminently suicidal tendencies; or
- * The member has unrealistic expectations of what can be accomplished from the program (i.e., member expects an immediate cure); or
- * The member is medically unstable (e.g., due to uncontrollable high blood pressure, unstable congestive heart failure, or other medical conditions); or
- * Member has previously failed an adequate multidisciplinary (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF) accredited) chronic pain management program.

Pain is considered chronic if it results from a chronic pathological process, has recurred periodically over months or years, or persists longer than expected after an illness or injury. Typically, pain is considered chronic if it has persisted for 6 months or more.

Modality-oriented pain clinics and single disciplinary pain clinics are considered not medically necessary and inappropriate for comprehensive treatment of members with chronic pain.

Note: Dependence or addiction to narcotics or other controlled substances is frequently part of the presentation of a member with chronic pain. Issues surrounding addiction, detoxification must be considered and evaluated prior to enrollment of a member into a pain management program.

MMPI: Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain. The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the patient's levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain patients:

- *Conversion V profile*: An elevation of scores on the hypochondriasis scale (scale 1, Hs) and hysteria scale (scale 3, Hy), with at least 10 points greater on these scales than on the depression scale (scale 2, D).

Evidence of this profile has been interpreted as evidence of a preexisting personality that is a major contributing factor in chronic low back pain, although this is disputed. Elevations of hypochondriasis (scale 1) and hysteria (scale 3) have been found to negatively correlate with return to work.

- *"Neurotic triad"*: has been coined to describe a cluster of elevated scores of hypochondriasis, depression and hysteria. Evidence has been supportive that these scales are consistently elevated in pain patients, predicting both decreased short- and long-term pain relief. Evidence has also been found to be conflicting as to whether scales 1 and 3 are associated with functional impairment related to pain.

- *PAIN*: A clustering of pain scales based on the MMPI that was described by Costello, et al., including the following: **P**: Nearly all scales are elevated; **A**: The Conversion V profile; **I**: The "neurotic triad"; & **N**: Normal.

Criteria for Use of the MMPI:

- (a) To determine the existence of psychological problems that are comorbid with chronic pain;
- (b) To help to pinpoint precise psychological maladjustment and help to tailor treatment;
- (c) To garner information that may help to develop rapport and enhance level of motivation;
- (d) To detect psychological problems not discussed in the clinical interview. One particular area that may be helpful is the use of the Addiction Acknowledgement Scale.

([McGrath, 1998](#)) ([Ruchinkas, 2000](#)) ([Slesinger, 2002](#)) ([Chapman, 1994](#)) ([Trief, 1983](#)) ([Arbisi, 2004](#)) ([Vendrig, 2000](#))

Psychological evaluations: Recommended. *Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations.* Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. ([Main-BMJ, 2002](#)) ([Colorado, 2002](#)) ([Gatchel, 1995](#)) ([Gatchel, 1999](#)) ([Gatchel, 2004](#)) ([Gatchel, 2005](#))

Cognitive therapy for depression: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ([Pampallona, 2004](#)) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ([Royal Australian, 2003](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. ([Warren, 2005](#))

ODG Psychotherapy Guidelines:

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Chronic pain programs: Recommended where there is access to programs with proven successful outcomes, 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 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](#))

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 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. ([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](#)) See also [Chronic pain programs, early intervention](#); [Chronic pain programs, intensity](#); [Chronic pain programs, opioids](#); and [Functional restoration programs](#).

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, including baseline functional testing so follow-up with the same test can note functional improvement;
- (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;
- (4) 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; &
- (6) Negative predictors of success above have been addressed.

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 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:

- 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)**