

Independent Resolutions Inc.

An Independent Review Organization

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IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: JUNE 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program (CPMP) five times per week for two weeks, ten sessions

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

American Board of Anesthesiology

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Chronic pain evaluation, 02./09/07

Evaluations, Dr., 02/08/07, 03/15/07, 04/23/07, 05/08/07

Initial program evaluation, physical therapy, 03/15/07

Daily physical therapy progress notes, 04/24/07, 04/25/07, 04/26/07, 04/27/07, 04/30/07, 05/07/07, 05/08/07, 05/09/07, 05/10/07 and 05/11/07

Group therapy notes 4/24/07, 4/25/07, 4/26/07

Weekly progress report, 04/26/07

Dr. report, 04/26/07
Case conference, 05/03/07 and 05/10/07
Utilization reviews, 05/17/07 and 05/25/07
Appeal letter, 05/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This male who worked as a landscaper was injured when stepping over buckets and caught his knee between the buckets and fell. The history provided in the records indicated that he injured his left knee on that date and while he was waiting for surgery on his left knee he fell 4 feet off a porch when his left knee gave out and he landed on his shoulders and neck. He had anterior cervical discectomy and fusion but continued to have neck pain post operatively. On 01/17/03 he had a posterior fusion for pseudoarthrosis. He has applied for social security disability. At the 02/08/07 visit with Dr., a chronic pain evaluation was ordered. The claimant has a diagnosis of chronic pain syndrome. The claimant underwent a psychological evaluation on 02/09/07 for a comprehensive multidisciplinary chronic pain management program and was felt to be an excellent candidate. Medications included Zoloft and Elavil. He was also taking Talacen, Robaxin and Neurontin four times a day. A component of the program would consist of an opiate extinction protocol.

Dr. evaluated the claimant. The claimant complained of cervical pain to the intrascapular area and bilateral trapezial area; worse on the left side and numbness in the ulnar distribution of the left and right hands. The claimant had tenderness of the left and right trapezius; motor strength was 5/5 and there was hypesthesia over the left and right ring and small fingers. Reflexes were 2 plus. The diagnosis was chronic pain syndrome and residual neck pain status post cervical surgery. The physician recommended a chronic pain program. He planned that the Talacen would be reduced by 25% at end of first week with an additional 25% reduction at the end of each subsequent week and a plan that the claimant would be opiate free by the conclusion of the 4 week program.

The claimant began the pain management program on 04/24/07. As of 04/26/07, he was taking pentazocine three times a day. The program consisted of psych, behavioral counseling and physical therapy. After the first week the claimant suffered an exacerbation of pain with lifting and the program was placed on hold for a week. A Medrol Dosepak was prescribed. Dr. note indicated an episode of chest wall pain with a diagnosis of costochondritis.

The claimant completed the second week of the program from 05/7/07 to 05/11/07. A case conference occurred on 05/10/07. The claimant was noted to have decreased his Beck scores and increased his lifting ability and was starting to wean off a cane. He had reduced his Talwin from three times a day to two times a day. His BDI had gone from 28 to 21, BAI from 40 to 14, BHS from 16 to 2 and ODI from 54 to 46. Physical gains between the completion of week one and week two were noted to be a lifting increase floor to knuckle from 41.5 to 65#, from knuckle to waist 51.5 to 55# and from waist to overhead 41.5 to 50#. As of 05/10/07 the claimant could tolerate sitting 30 minutes, standing 20 minutes with a cane, walking 40 minutes, squatting 10 minutes x 5, occasional reaching and climbing 20 minutes. The claimant was noted to be

progressing in group therapy with pain management techniques. A two week extension was requested to continue the gains made thus far.

The additional two weeks was denied on utilization review of 05/17/07 which indicated that the second week was not completed. A second review was done on 05/25/07 which addressed the completion of the second week noting evidence of improvement in mood and reduction of opiates but did not have data from the physical aspects of the program showing his progress.

An appeal letter was submitted dated 05/27/07 that outlined the claimant's physical progress per the Case Conference of 5/10/07 which documented increased lifting capability. It was noted that functional ability had also shown improvement with the claimant being able to tolerate cardiovascular exercises and extended walking. Although the claimant complained of increased pain he had a decrease in his BDI and BAI while in the program.

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

The claimant is a landscaper, who was injured. More recent debilitating injuries focused on the cervical region with multiple procedures for fusion and pseudoarthrosis. The claimant was enrolled in a comprehensive pain management program involving psychological counseling, behavioral counseling and physical therapy on 04/20/07. He had clear improvement under this program, which resulted in lower depression scores, increased levels of activity, and decreased narcotic use. There was some question of whether he completed the second week, which was addressed in a subsequent missive from the provider. A second two weeks of treatment are warranted considering the benefit the patient had derived from the initial program. Subsequent improvement must be continued on an outpatient basis with the assistance of a home exercise program and outpatient therapy.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Chronic Pain.

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. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) 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.

(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.

(2004) (2006) See Functional restoration programs.

Functional Restoration Programs:

Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs), were originally developed. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) 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) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see Chronic pain 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)