

# True Resolutions Inc.

An Independent Review Organization

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## IRO REVIEWER REPORT TEMPLATE -WC

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**DATE OF REVIEW:** 10/12/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program 5x2

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

Clinical psychologist

### **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**

08-04-05 Initial diagnostic interview- LPC  
09-02-05 RME report for, MD  
09-07-05 EMG testing report-, MD  
09-13-05 Mental health eval-, LPC  
10-06-05 DD report-, MD  
11-09-05 Follow-up EMG testing-, MD  
11-01-05 to  
12-25-05 IT treatment progress reports-, LPC  
02-22-06 to  
05-19-05 IT treatment progress reports-, LPC  
08-31-06 to  
11-30-06 IT treatment progress reports-, LPC  
06-25-07 IT treatment progress report and request for LPC

08-20-07 treatment progress report  
08-24-07 Denial letter by, MD  
09-06-07 Denial letter by, PhD  
No ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured performing her job duties while working for. On xx/xx/xx, patient was in the process of using a wrench to assemble a part when she twisted her wrist, experiencing immediate pain throughout her hand and fingers. She was given appropriate diagnostics and treated with appropriate conservative therapies. EMG reports in 2005 state that patient showed evidence of “very severe sensorimotor peripheral neuropathy on the right, and a motor greater than sensory neuropathy on the left.” The doctor further stated that “unfortunately, there have been medical disputes with her claim, and this has held up appropriate surgery.” In 2005, designated doctor also stated that the patient was not expected to reach MMI until 2 years post her date of injury, and that “The patient may suffer sudden or subtle incapacitation” over the course of her treatment.

Patient eventually received bilateral carpal tunnel releases on 8-16-06 and 11-8-06. In addition to these two surgeries, patient has received physical therapy, individual psychotherapy, steroid injections, and medical pain management. She currently carries the following diagnoses: S/P bilateral carpal tunnel release, wrist contusion, trigger finger (acquired), medial epicondylitis, carpal tunnel syndrome, bilateral ulnar nerve neuropathy, depressive disorder, and pain disorder associated with medical condition and psychological factors.

Patient was approved for, and completed, the first ten days of a chronic pain management program, but the last ten days were denied x 2.

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

Patient met ODG and ACOEM criteria for a chronic pain program, and was allowed to attend the first 10 days of a 20-day program. Research supports that 20 days is the standard of care for these patients, and is typically needed to completely rehabilitate and return a patient to work. The full program can be recommended when a patient shows evidence of subjective and objective gains during the first two weeks.

In this case, patient has shown improvement, and/or stability, across all measures, with the exception of reduction in her pain medications. She should be emotionally and physically prepared to start this weaning process, which is planned to begin upon return to the program. Patient has already made contact with, and the goals for continuation of the program, which are to continue to facilitate a safe and appropriate return to work with increased functioning and decreased reliance on pain medications, is medically reasonable and necessary.

**See the following ODG treatment guidelines:**

**Weaning of medication: Recommended** as indicated below. For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. ([Benzon, 2005](#)) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition, (b) Clear written instructions should be given to the patient and family, (c) If the patient can not tolerate the taper, refer to an expert (pain specialist, substance abuse specialist), (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal), (e) Greater success may occur when the patient is switched to longer-acting opioids and then tapered, (f) Office visits should occur on a weekly basis, (g) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS), and (h) Recognize that this may take months. For benzodiazepines, tapering is required if used for greater than 2 weeks. ([Benzon, 2005](#)) ([Ashton, 2005](#)) This is more dangerous than opioid withdrawal, and takes more time, with the following recommendations: (1) The recommended rate of tapering is about 1/8 to 1/10 of the daily dose every 1 to 2 weeks, (2) Rate of withdrawal should be individually tapered, (3) Tapering may take as long as a year, (4) High-dose abusers or those with polydrug abuse may need in-patient detoxification, and (5) Withdrawal can occur when a chronic user switches to a benzodiazepine with a different receptor activity. ([Lee, 2002](#)) For carisoprodol (Soma®), this medication is metabolized to meprobamate, a barbiturate. At the highest levels of barbiturate tolerance, the patient is at risk of delirium, seizures or even death with abrupt discontinuation. ([Heacock, 2004](#)) ([Washington, 2002](#)) See also [Detoxification](#); & [Rapid detox](#).

**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](#)

**Dysvik E, Natvig GK, Eikeland OJ, Brattberg G. Results of a multidisciplinary pain management program: a 6- and 12-month follow-up study. *Rehabil Nurs*. 2005 Sep-Oct;30(5):198-206.**

**Haldorsen EM, Grasdal AL, Skouen JS, Risa AE, Kronholm K, Ursin H. Is there a right treatment for a particular patient group? Comparison of ordinary treatment, light multidisciplinary treatment, and extensive multidisciplinary treatment for long-term sick-listed employees with musculoskeletal pain. *Pain*. 2002 Jan;95(1-2):49-63.**

Sanders SH, Harden RN, Vicente PJ. Evidence-Based Clinical Practice Guidelines for Interdisciplinary Rehabilitation of Chronic Nonmalignant Pain Syndrome Patients. World Institute of Pain, *Pain Practice*, Volume 5, Issue 4, 2005 303–315.

See also: Patrick LE, Altmaier EM, Found EM. Long-term outcomes in multidisciplinary treatment of chronic low back pain: results of a 13-year follow-up. *Spine*. 2004 Apr 15;29(8):850-5.

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**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)**