

# Applied Resolutions LLC

*An Independent Review Organization*  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/05/08

**IRO CASE #:**

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

Chronic Pain Management Program, 20 sessions

### **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)

Upon independent review the reviewer finds that the requested 20 sessions of Chronic Pain Management Program is medically necessary

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 1/25/08, 2/21/08  
ODG Guidelines and Treatment Guidelines  
Functional Capacity Exam 5/15/07 and Evaluation 5/16/07  
Functional Capacity Exam 6/18/07 and Evaluation 6/18/07  
Daily Program Progress and Symptom Report 6/4-6/8/07 and 6/11-6/15/07  
Patient Status Letter 1/19/08  
Treatment Update 12/11/07  
Functional Capacity Exam and Notes 12/11/07  
Request For Appeal 2/9/08

Peer Review 2/7/08  
MD Exam 12/31/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained a work-related injury while performing his job duties as a xxx. Patient was doing ion work when he fell approximately 15 feet, sustaining injuries to the head, face, neck, shoulders, and wrist. Patient was transported to the ER, where diagnostics revealed bilateral nasal fracture with septal fracture. Cervical disk protrusions were identified from C2-C7, and patient continues to have restricted cervical range of motion and chronic headaches. Lumbar MRI showed disc dehydration at L1-L2, chronic compression to the L3 vertebral body involving the superior endplate, and broad based disk bulges at multiple lumbar levels. Lumbar EMG showed bilateral L5-S1 nerve root impingement and cervical radiculopathy. Over the course of his treatment, patient has received physical therapy, medication management, ESI's, Marcaine injection to the wrist, nasal surgeries x2, teeth pulled with plates, FCE which showed Sedentary PDL abilities, and 10 days of work hardening with group psychotherapy. Patient received a 12% whole person impairment rating. Primary medication for pain appears to be Hydrocodone.

On 11-1-07, at the time of the initial eval for CPMP, claimant had not responded significantly to most of the previous mentioned interventions and was continuing to report 5/10 pain levels and exhibiting the following symptoms: low back pain, neck pain, frequent headaches, hopelessness, difficulty sleeping, and difficulty with prolonged sitting, standing, bending, or stooping activities. Patient had decreased lumbar and cervical range of motion. Diagnoses included: Lumbar and cervical disk herniation, lumbar and cervical radiculopathy, chronic pain, chronic myospasm, and, mild levels of depression and anxiety as measured by BDI and BAI. Current request is for 20 day CPMP with goals of reduced pain, improved function, vocational counseling, return to work, reduced reliance on pain medications, and improved mental status.

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

Patient is obviously a chronic pain patient and meets ODG and ACOEM criteria for a chronic pain program. Twenty sessions meets the minimum requirements for this patient, given that subjective and objective functional improvements are happening. The best hope for the patient to return to productivity is from such a program.

Patient has had numerous adequate and independent evaluations, previous treatment methods have been unsuccessful, he has a significant loss of ability to function independently resulting from the chronic pain, and has shown both subjective and objective improvements during the first part of the CPMP. As such, the requested sessions meet criteria for reasonableness and medical necessity.

ODG recommends CPMP for this type of patient, and ODG supports using the BDI and BAI, among other tests, to establish baselines for treatment. [Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 2001.](#)

See also:

Mayer TG, Gatchel RJ, Mayer H, Kishino ND, Keeley J, Mooney V. A prospective two-year study of functional restoration in industrial low back injury. *JAMA*. 1987 Oct 2;258(13):1763-7.

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.

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.

**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.

**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)**