

# IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0310

**DATE OF REVIEW: 02-4-08**

**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**

No ODG Guidelines

01/30/07 Office note; Dr. DC  
02/02/07 Radiology report of left shoulder; MD  
02/13/07 EMG report; Advanced Diagnostics  
02/14/07 Lumbar MRI; Up and Open Imaging  
05/17/07 Behavioral medicine evaluation; LPC  
10/29/07 Neurosurgical Report; Dr.  
12/05/07 Chronic Pain Management Program request; LPC  
12/11/07 First Denial; Dr.  
12/18/07 Initial H&P; DO  
12/27/07 Reconsideration request; LPC  
01/18/08 Response to Denials; LPC

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

The claimant is a female who was injured performing her job duties as a xxx for a school district. The patient was in the process of climbing down a ladder when she missed the last step and fell, injuring her left ankle, shoulder, and low back. Over the course of her injury, patient has received ESI's, facet blocks, piriformis block, physical therapy, individual psychotherapy, medication management, and 20 days of work hardening program. Diagnostic shoulder report of 2/2/7 was unremarkable, as was the EMG/NCV. Lumbar MRI was positive for L4/L5 2mm disc protrusion and L5/S1 annular bulge. Designated doctor report ruled out surgical intervention, as did diagnostic shoulder report by Dr. She currently carries diagnoses of 722.10- lumbar IVD; 296.23- MDD, severe; 307.89-Pain disorder; 724.4 – lumbosacral neuritis. Current medications include: Lyrica 75 mg, Paxil 20 mg, and OTC Advil.

Patient is performing at a Sedentary PDL level, and needs to be at a Medium PDL in order to return to work. Patient appears to have been compliant with all of the serially administered interventions that have been afforded her thus far, but has not been able to improve her overall pain level or functioning in a significant way. During work hardening, she was able to improve her reports of irritability, frustration, muscle tension, family discord, and sleep disturbance. Patient was unable to be successful in meeting the RTW goals of the WH program, and the current request is for 20 days of a CPMP.

Goals for the program include return to work, decreasing average reported pain level from 8 to 3, increasing sleep from 6 to 8 hours per night, and decreasing depression and anxiety from self-reported 9/10 to 4/10.

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

Patient meets ODG and ACOEM criteria for a chronic pain 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 during the work hardening program, with the exception of reduction in her anxiety and vocational distress.

It appears that the best hope for the patient to return to some sort of ability to self-care and be productive is from such a program. ODG requires that these services be rendered by a program with proven results, and a CARF-accredited program meets these requirements.

Patient has had numerous adequate and independent evaluations, previous treatment methods have been unsuccessful, she has a significant loss of ability to function independently resulting from the chronic pain, she is not a surgical candidate, and she appears to exhibit motivation to improve. As such, the requested 20 sessions meet criteria for reasonableness and medical necessity.

ODG recommends CPMP for this type of patient. (See the following):

**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](#)) ([Gatchel, 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.

**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)**