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Notice of Independent Review Decision

DATE OF REVIEW: January 14, 2008 AMENDED DECISION 1/18/08

IRO CASE #:

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

This case was reviewed by a PM & R (Board Certified) doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Functional restoration program, five times per week for six weeks (30 visits)

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- November 30, 2007 non-authorization letter from
- December 14, 2007 non-authorization letter from
- September 17, 2007 confidential neuropsychological report by, Ph.D.
- October 15, 2007 through November 5, 2007 individual counseling notes from, LMFT, ATR-BC August 7, 2007 decision and order by, hearing officer
- June 6, 2006 RS Medical prescription sheet by
- November 27, 2007 functional restoration/opiate step-down program request report by, Ph.D.
- June 6, 2006 letter by, M.D.
- June 7, 2006 follow-up visit note by, M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. A November 30, 2007 utilization review letter states that functional restoration program of five times per week for six weeks consisting of 30 visits was requested. A non-certification was rendered on the clinical basis that the patient had a chronic cervical and lumbar pain and had completed 20 sessions of chronic pain management program in May of 2006. The patient had reportedly worsening symptoms with increasing anxiety and depression. The provider then requested a functional restoration program. The physician reviewer saw no indication for the requested program since the patient had already completed a program of this type.

On December 14, 2007, another non-certification was rendered for the request. The clinical basis for non-authorization was listed as follows: "The claimant has completed IT and biofeedback sessions followed by chronic pain management program times 20 followed by a neuropsychological evaluation and additional IT. There is a request for another chronic pain management program mainly for detox from her medications. Apparently, the claimant had some issues previously when trying to come off of medications when she became suicidal and had psychotic symptoms and they are concerned about this happening again. Dr. reported that they have already begun decreasing her medications. The claimant reportedly will likely be able to return to working and there is the possibility of different job options depending on her PDL. While it is understandable that the claimant is on a lot of medications and has had trouble when decreasing her medications in the past, there has been no significant event

such as surgery since her last program. It is not established that the pain management program is the appropriate treatment for this situation, particularly since she has had one in the past and is still having difficulties. Based on the available information, the request does not appear to be reasonable."

A November 27, 2007 functional restoration/opiate step-down program request report was submitted for review. The patient was referred for the functional restoration program by her treating doctor to continue the weaning process he had begun with her in a safe, supervised, and systematic way. The patient's chief complaint is noted to be neck and lower back pain radiating down the upper and lower extremities bilaterally, severe depressed/anxious mood, headaches, and poor sleep.

The report notes that the patient had six sessions and two biofeedback sessions in early 2006. The patient made progress reducing her anxiety and depression from the sessions. She was then approved for 20 sessions of a chronic pain management program. She was often suicidal and began having depression with psychotic symptoms during this time period, mostly attributable to her fear of losing her productivity and her quality of life. However, she actively participated and progressed in the program which ended in May 2006 according to the report. The primary accomplishments during this program were increased activities of daily living by 15%, decreased panic attacks by 50%, decreased suicidal and psychotic symptoms by 75%, and a decrease in her depression scores by 60%. She was then recommended for an additional 10 days and this request was non-certified. The physician reviewer reportedly noted that the patient has postconcussive headaches and is somewhat unstable and continuing to have difficulty. After having benefits restored through a court case, the patient returned to the facility. Her treatment was reportedly severely hampered as her psychometric scores were back to baseline, along with her pain scores. As such, the patient had increased her pain and psychotropic medications. All gains that were made in the chronic pain management program were effectively lost according to the report.

Her medications were listed as follows: Vicodin ES q.i.d., Ultram ER 300 mg q.d., Detrol LA 4 mg q.d., Topamax 50 mg two h.s., Relpax 40 mg one stat, Cymbalta 60 mg h.s., Abilify 15 mg q.d., Librium 25 mg q.i.d., Ambien 12.5 mg h.s., Prevacid 30 mg q.d., and Phenergan 25 mg one to two as needed for nausea. The report summary states that after psychological testing and clinical interview, the patient was found to not be psychotic and was oriented times five. The patient's current pain level is significantly interfering with her ability to perform daily life activities and decreasing her quality of life. The patient was noted to be experiencing suicidal ideation, but without plan or intent.

The report states that narcotic medications will be stepped down 20-50% per week in accordance with the ODG guidelines and Suboxone will be added if necessary to control for cravings. Treatment would consist of medication management, individual therapy, psychodynamic group therapy, biofeedback, aquatic therapy, case management, work simulation, neuromuscular reeducation, massage therapy, and team treatment staffing.

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

The medical records now reflect that the patient made significant gains over the course of the initial chronic pain management program rendered in 2006. Further treatment was non-certified at that time and the patient reportedly lost the gains that she had made. The patient's treating doctor and a second physician that had prescribed medications agreed that the patient should start a functional restoration program. The prescribing physician recommended against abrupt cessation of her medications. The patient has been noted to have current significant pain levels, decreased activities of daily living, anxiety, depression, and opioid dependence. Given that the patient did have a good response to previous chronic pain management, initiation of a functional restoration program is indicated. Therefore, my recommendation is to overturn the previous decision to non-certify the request for functional restoration program, five times per week for six weeks (30 visits).

The IRO's decision is consistent with the following guidelines:

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

__X__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

Official Disability Guidelines (2008):

Detoxification: Recommended as indicated below. Detoxification is defined as withdrawing a person from a specific psychoactive substance, and it does not imply a diagnosis of addiction, abuse or misuse. May be necessary due to the following: (1) Intolerable side effects, (2) Lack of response, (3) Aberrant drug behaviors as related to abuse and dependence, (4) refractory comorbid psychiatric illness, or (5) Lack of functional improvement. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) See also Rapid detox.

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 by Mayer and Gatchel. 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 Cochrane 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 Cochrane 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 Cochrane 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.

Chronic pain management 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 treatment; (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)

Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) 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 and there is an absence of other options likely to result in significant clinical improvement; (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 or other treatments 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. Total treatment duration should generally not exceed 20 sessions. (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The patient should be at MMI at the conclusion.

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.