

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: July 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 5 X 2

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in 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

OD Guidelines

Denial Letters 7/21/08 and 7/18/08

Records from Dr. 6/5/08 Including Treatment Plan

Medical Records from Dr. 2/6/08 thru 5/30/08

MRI 1/16/08

Letter from 7/25/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This lady was injured in xx/xx. She subsequently underwent a lumbar fusion from L4-S1. The MRI in January 2008 reported a solid fusion and no nerve root compromise. She was diagnosed with chronic pain and postlaminectomy syndrome. She had been in a pain program in 2002, but regressed. Dr. noted that she acknowledged making some improvement with the prior counseling and then regression. Her emotional situation

apparently has deteriorated. She has severe depression (Beck Depression Inventory 29), moderate anxiety (Beck Anxiety Inventory 11), and a high risk for substance abuse with a SOAPP score of 18. She has apparently preexisting dysthymia with aggravation including with a family member death in a motor vehicle accident during her recent assessment. She is currently on the following controlled substances: Methadone (20mg bid), Lyrica (150mg in the am, 300 qhs), Norco (10mg qid), plus Baclofen, Zanaflex, Relafen and one note regarding Cymbalta. She is felt to be misusing the medications with resultant functional impairment from the pain medications. She is described to be feeling sad, hopeless, depressed, and anxious. Her pain level is generally 9-10 and the pain interferes with many of her activities of daily living. She had 6 prior sessions of individual therapy addressing her coping skills. There is a request for 20 more sessions of a multiple specialty approach with the goal of improving her outlook and function.

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

One requirement is patient motivation to both improve and return to work. There does not appear to be a goal for this lady to return to work. Rather, the plan is a combination of physical and psychological therapies. Further how outlook for work is a negative factor. There is the issue of inappropriate use of pain medicine. This is also a predictor of an adverse outcome. The issue that her problem being chronic is not considered to be a factor. A baseline FCE is usually supplied. None was done.

Chronic pain programs (functional restoration 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)...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](#)) ...

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 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. The patient should be at MMI at the conclusion.

Further, she is not demonstrating improved pain relief, quality of life and function with the pain medications. Additional psychological or psychiatric treatment would be more appropriate. This is addressed in both the ODG and Texas Medical Board Rules, Chapter 170.3. The ODG would also support the discontinuation of the opioids due to lack of improvement. This can be very difficult. It is possible that she was more functional in the past, but not at this time.

Chronic pain programs, opioids

Recommend assessing the effects of interdisciplinary pain programs on patients who remain on opioids throughout treatment, and to determine whether opioid use should be a screening factor for admission to or continuation in a program. The limited research that is available indicates **that daily opioid use, in low doses, does not decrease effectiveness of chronic pain programs**. Early research also indicates that **simultaneous dependency/addiction programs with pain programs may be a viable option**. Limited studies allow for an evaluation of the role of the chronic use of opioids on treatment success in interdisciplinary pain programs:

- (1) The original Mayer et al. studies ([Mayer, 1985](#)) ([Mayer, 1987](#)): The comparison group was comprised of patients who were denied treatment by their insurers. A third group were those patients who were non-completers (10%). Prior to the actual functional restoration program (FRP), the patients in the program were treated with an introductory 3-6 week session that included tapering of habituating medications. The results of this pre-treatment may be reflected in the fact that only 15% of the treatment group were taking opioids versus 48% in the non-treatment comparison group (significant at $P < 0.05$). The final results showed that 87% of the treatment group was actively working after two years compared to 41% of the non-treatment group (with results based on patients that the researchers were able to contact after the time period). Only 13% of the group of patients who decided not to complete the program (the third group) returned to work at one year. The role of the program design that included tapering of medications on treatment results was not discussed.

- (2) **Simultaneous opioid withdrawal and pain rehabilitation: Research evaluating simultaneous opioid withdrawal with pain rehabilitation programs (in an analysis of predominately female, non-workers' compensation patients), found that all patients that completed the program (regardless of opioid use on initial entry) showed decreased pain severity and catastrophizing, although those taking opioids had significantly higher scores at the three-week discharge for these variables.** ([Rome, 2004](#))

- (3) Programs that don't emphasize opioid tapering: A more recent study of patient's receiving workers' compensation benefits in a program that did not stress opioid withdrawal found that at 6 months, 72.1% of opioid users returned to work versus 75.8% of non-opioid users, a non-significant difference. The mean

dose of daily morphine equivalents was 28.63 mg (range 0.53 mg to 150 mg), which may limit the generalizability of the study. ([Maclaren, 2006](#))

Opioids, criteria for use

CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:

(a) Are there reasonable alternatives to treatment, and have these been tried?
(b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?

(c) Is there likelihood of abuse or an adverse outcome? See [Substance abuse \(tolerance, dependence, addiction\)](#).

(d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: **(1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has had a psychological evaluation and has been given a diagnosis of somatoform disorder. (3) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression).**

(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a **clinical decision to withhold opioid medications should document the basis for their decision...**

4) On-Going Management. Actions Should Include:

(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.

(b) The lowest possible dose should be prescribed to improve pain and function.

(c) Office: **Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of [function](#), or improved quality of life.** Information from family members or other caregivers should be considered in determining the patient's response to treatment. ***The 4 A's for Ongoing Monitoring:* Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. ([Passik, 2000](#))**

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) **Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.**

(f) **Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).**

(g) Continuing review of overall situation with regard to nonopioid means of pain control.

(h) Consideration of a consultation with a [multidisciplinary pain clinic](#) if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months.

Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse...

6) When to Discontinue Opioids: See [Opioid hyperalgesia](#). Also see [Weaning of Medications](#). Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can

be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.

(a) If there is no overall improvement in function, unless there are extenuating circumstances

(b) Continuing pain with the evidence of intolerable adverse effects

(c) Decrease in functioning

(d) Resolution of pain

(e) If serious non-adherence is occurring

(f) The patient requests discontinuing

(g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.

(h) Many physicians will allow one “slip” from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.

(i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. ([Weaver, 2002](#))

(j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

7) When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain

**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)