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MEDICAL RECORD REVIEW:

DATE OF REVIEW: 07/10/2008

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 Pain Management, 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

Chronic pain management program – 10 day additional outpatient

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- June 2, 2008 Progress Assessment from, PT
- June 3, 2008 Preauthorization request for continuation of CPMP from Dr.
- June 8, 2008 Adverse determination report for continuation of CPMP
- June 12, 2008 Treatment goals for CPMP from Dr.
- June 13, 2008 Request for reconsideration for 10 days in a CPMP from, MA, LPC
- June 20, 2008 Adverse determination report for reconsideration of CPMP
- July 1, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records provided for my review, the patient is a for a company who sustained an industrial injury to the low back on xx/xx/xx associated with lifting very heavy stones. The patient speaks only Spanish. Appropriate treatment of chiropractic and physiotherapy modalities, nerve conduction studies, MRI and 9 sessions of physical therapy were provided by an occupational clinic. The patient transferred his care to a chiropractic clinic seeking better improvement. The patient has not worked since February 8, 2007.

EMG conducted February 6, 2007 indicates compressive nerve root irritation of the right L5 level.

Lumbar MRI of February 7, 2008 shows at L5-S1 a broad-based left paracentral 4 mm disc protrusion contacting and displacing the traversing left S1 nerve root posterior and mildly compressing the left anterolateral aspect of the thecal sac with no foraminal stenosis. At L4-5 there is a broad-based posterocentral disc protrusion that is 3.5 mm in AP dimension migrating inferior 2 mm and effacing the ventral surface of the thecal sac.

The patient was approved and participated in 20 days of a chronic pain management program (CPMP).

On June 3, 2008 request was made for continuation in the CPMP for an additional 10 sessions. An assessment completed June 2, 2008 shows 6 indicators have been reduced, 2 have not changed, no change in frustration and anxiety, and a one indicator has increased -- pain level has increased associated with PPE efforts. The patient continues to report numbness and tingling in the bilateral lower extremities rated as 4-5/10. He reports difficulties with activities of daily living. Testing shows slight improvements in lower extremity motor strength, range of lumbar motion and lift capacity. The plan is to return the claimant to his original position as a lwhich requires a Heavy PDL. If the patient cannot attain the necessary PDL he has an interest in working as a ranch hand or as a porter for a hospital. The next 2 weeks of care will focus on increasing the patient's functional tolerance and realizing a realistic vocational plan. ODG requires a clear rationale for specific extension of CPMP treatment in excess of 20 sessions which is herewith established.

On June 9, 2008 request for 10 additional CPMP sessions was not certified in review with rationale that the request was not reasonable or medically necessary as the patient has now had 20 sessions of CPMP as well as work hardening earlier in 2008 with minimal functional gains: From light PDL to Light-Medium PDL. It was noted that adequate documentation of subjective complaints, objective physical findings, neurologic deficits, and special circumstances, are necessary for consideration of requests, especially those that fall beyond the recommendations of the Evidence-Based Medical Guidelines, and these were not provided. Per a peer-to-peer discussion with the provider, the patient can currently lift 45-54 pounds which is very close to medium level PDL. He does a daily HEP of stretches and cardio and has a job available at Medium PDL level.

On June 13, 2008 request for reconsideration for 10 additional CPMP sessions was submitted. The patient has made some inquiries with possible employers. If he reaches a Medium PDL he will have more viable job options available to him. The patient is 1.5 years post injury and has a diagnosis of failed back syndrome. The patient can return to his job if he can achieve a Heavy PDL. He has developed a chronic pain syndrome which is improving. Additional CPMP sessions are needed to reduce his pain experience, develop self-regulation skills, facilitate a timely return to work and obtain medical case closure.

On June 20, 2008 request for reconsideration of additional pain management of 10 sessions was not certified in review with rationale that the medical records failed to document clinically appropriate rationale for treatment duration in excess of 20 sessions as required by guidelines. ODG notes that effective outcome for CPMP can be accomplished in less than 20 days and rarely more than twenty days are needed. The additional documentation provided does not justify extending the Program beyond recognized standards. Per guidelines, after a standard program is completed, patients should be encouraged to function "more independently", to self-manage psychological symptoms and "reducing ongoing dependency on the interdisciplinary team and services".

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

The medical records document a patient who has almost attained a Medium PDL after 1.5 years of treatment including work hardening and 20 sessions of CPMP. The medical records document slight improvements with 20 sessions of CPMP. As noted in prior review, the patient can currently lift 45-54 pounds which is very close to medium level PDL. He does a daily HEP of stretches and cardio and has a job available at Medium PDL level. A plan to return the patient to Heavy PDL status is unreasonable in light of his lumbar herniation and minimal progress to date. The patient can reasonably attain a Medium PDL with additional rehabilitation and time.

ODG notes that effective outcome for CPMP can be accomplished in less than 20 days and rarely more than twenty days are needed. 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. There is a very high standard for circumstances and documentation to warrant CPMP of more than 20 sessions. The medical records fail to provide documentation of a level that would meet the required criteria for extension of CPMP beyond the recommended duration. The claimant does a daily HEP of stretches and cardio and has a job available at Medium PDL level. As per ODG, after a standard program is completed, patients should be encouraged to function "more independently", to self-manage psychological symptoms and "reducing ongoing dependency on the interdisciplinary team and services. The claimant could be transitioned to his HEP at this time for completion of his rehabilitation. Therefore, my recommendation is to agree with the previous non-certification of the request for 10 additional sessions in an outpatient chronic pain management program.

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

The Official Disability Guidelines – Chronic Pain Management Programs – 7-7-08:

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 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.
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.