

I-Decisions Inc.

An Independent Review Organization

71 Court Street Belfast,

Maine 04915 (207)

338-1141 (phone) (866)

676-7547 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 6/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 5 times a week times 2 weeks

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 Chronic Pain Management 5 times a week times 2 weeks is medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a old male who sustained a work-related injury. Patient was performing his usual job duties when he fell down stairs, injuring his lower back, neck, left shoulder, right knee and right ankle. Records indicate he received arthroscopic surgery to the right knee in 2004 and has received three injections that provided relief for a couple of weeks. He has received physical therapy and six session of individual psychotherapy in 2006.

MRI of the lumbar spine done 10-22-04 indicated 2 mm shallow diffuse posterior annular disc bulge at L4-L5, and 3-4 mm circumferential to diffuse posteriorly protruded disc and slightly extruding migrating inferiorly, more right paracentral

posteriorly with focal spinal and foraminal stenosis bilaterally at the L5-S1. MRI of the cervical spine shows a 1 mm posterior bulge at C2-C3 and a 1mm posterior bulge at C4 through C6. Patient was eventually diagnosed with lumbar disk herniation, thoracic facet pain, cervical radiculitis, medial meniscus tear-right knee, left shoulder impingement, left shoulder tendonitis, and chronic myospasm. He was evaluated on 09-19-07 by orthopedic surgeon, Dr. Due to patient's reluctance and co-morbid conditions of hepatitis C, cirrhosis of the liver and hypertension, surgical intervention was non-recommended.

Over the course of his treatment, patient received x-rays, MRI's, EMG/NCV, FCE, and has been treated conservatively with physical therapy, medication management, and individual therapy, with no overall improvement in his pain. Surgery is not recommended. Currently, he is managed medically with Lorcet and Soma.

At the time of the initial eval for CPMP, claimant was exhibiting the following injury-related symptoms: low back pain that is rated, on average, as an 8/10, (pain range is from 7-9 out of 10 VAS), difficulty sleeping, decreased ADL's, poor cardiovascular endurance, increased irritability and anger, depressed mood, anxiety, fear of re-injury, and decreased ROM and flexibility. FCE shows patient to be at a Sedentary PDL, and would need to be at a Medium PDL to return to his previous job. Patient is not currently working, but wishes to return to work and appears motivated to increase his overall functioning in order to do so. Patient has been referred for CPMP by his treating physician and goals include: reduction in depressed/anxious symptoms, decreased subjective pain levels associated with ADL's and work activities by 10%, increased activity and pain tolerance, reduced pain by 20% overall, implementation of pain management coping strategies, reduced anger by 50%, and development of a weaning protocol for his narcotic medication. This request is for the initial 10 days of a chronic pain management program.

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

Patient has continued low back pain with an identified pain generator, and has received evaluations from his treating medical doctor, a psychotherapist, and surgeon, all of whom agree patient's only alternative at this time is participation in a CPMP. Previous methods of treating the pain have been unsuccessful, and patient is not a candidate for surgery. Patient appears to have followed all doctor recommendations to this point, and reports motivation to continue to follow recommendations that would improve him so she can go back to work. He has a significant loss of ability to function independently resulting from the chronic pain, both physical and behavioral, and there are no reported contraindications in the records available for review that have not been discussed with the patient. Per ODG, patient has followed a stepped-care approach to treatment, and is now in the tertiary stages of his treatment. The denial based on patient's inability to undergo the physical portion of the program appears to be contradicted by the treating MD, who has outlined a specific physical rehab plan.

Therefore, the current request for Chronic Pain Management 5 times a week times 2 weeks is deemed medically reasonable and necessary, per ODG criteria.

Twenty days is generally established as meeting the minimum requirements for most patients, given that subjective and objective functional improvements are happening. Patient is not currently at clinical MMI, but should be at the end of the program.

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:

Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.

Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines](#) for low back problems. ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

Criteria for the general use of multidisciplinary pain management programs:2008

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.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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)**