

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 Sessions

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

Clinical psychologist

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

Adverse Determination Letters, 2/7/08, 1/25/08
ODG Guidelines and Treatment Guidelines, Chronic Pain Programs
DC, 11/1/07, 12/28/07
BS, DC, 1/17/08, undated, 3/15/07
PhD, LPC, 1/14/08, 11/14/07, 10/25/07, 7/16/07
MD, 1/26/06, 2/28/06, 11/8/05, 11/23/05, 12/2/05, 12/27/05, 3/28/06, 4/26/06, 4/4/06
Solutions, Pain Management Program Notes, 8/13/07, 12/6/07, 12/11/07, 12/12/07, 12/14/07,
12/18/07
MD, 8/2/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who sustained a work-related injury on xx/xx/xx. Patient was attempting to lift a roll of insulation weighing approximately 80 pounds when he felt immediate pain to his low back and abdominal area. Over the course of his treatment, patient has received physical therapy, medication management, ESI's, hernia repair, FCE which showed Medium PDL abilities, and work hardening. MRI of the lumbar spine revealed bulging at L4-L5 and L5-S1. EMG reportedly showed acute bilateral L5-S1 radiculopathy. Medications currently include Ultram 50mg qd, Motrin 600 every 12 hours, and Flexeril 10 mg as needed.

On 11-1-07, at the time of the initial evaluation for CPMP, claimant was exhibiting the following symptoms: low back pain radiating to the left lower extremity with numbness and tingling in the left lower leg and foot, difficulty sleeping, and difficulty with prolonged sitting, standing, bending, or stooping activities. Patient had decreased lumbar range of motion. Diagnoses included: Lumbar disk herniation, lumbar radiculopathy, chronic low back pain, chronic myospasm, insomnia, moderate depressive disorder with suicidal ideation, moderate anxiety disorder, and post-traumatic stress disorder.

The current request is for CPMP x 10 Sessions with the goals of reduced pain, improved function, vocational counseling, return to work, axiologic education, and a reduction in panic attacks.

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

This patient meets ODG and ACOEM criteria for a continuation of a chronic pain program, given that subjective and objective functional improvements are happening. According to the medical records provided, the patient has been able to improve his lumbar ROM to "essentially normal with continued pain at end range challenges." BDI has reduced to 15/63 from 25/63 and BAI fluctuates between 15 and 23, a reduction from initial at 30/63. Actual increases in functioning have begun to occur. PTSD continues to be a problem as evidenced by panic attacks and numerous fears related to his injury and off-work status.

The patient has had numerous adequate and independent evaluations, previous treatment methods have been unsuccessful, and he has a significant loss of ability to function independently resulting from the chronic pain. The patient has shown both subjective and objective improvements during the first part of the CPMP. As such, the reviewer finds that 10 additional sessions of CPMP meet the criteria for reasonableness and medical necessity and therefore, the reviewer will overturn the previous adverse determination(s).

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: Mayer TG, Gatchel RJ, Mayer H, Kishino ND, Keeley J, Mooney V. A prospective two-year study of functional restoration in industrial low back injury. *JAMA.* 1987 Oct 2;258(13):1763-7.

[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.

[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.

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](#)) ([Gatchel2, 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.

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)**