

# IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** 10/23/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program 5x4

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 9/16/08 and 9/24/08

Records from 5/14/08 thru 10/08/08

FCE's 9/2/08, 7/30/08, and 3/4/08

Records from Dr. 4/1/08 thru 9/23/08

Records from Dr. 4/28/08

MRI's 2/19/08 and 3/17/08

IRO Decision 7/9/08

Letter from 10/7/08

Record 12/20/04 thru 2/22/08

Records from Dr. 5/14/08 thru 6/12/08

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who sustained a work-related injury on xx/xx/xx while working . Patient was performing her usual job duties when she injured her right upper extremity while lifting boxes weighing 35-40 pounds. Records indicate she felt immediate pain in the back and neck when she attempted to put the boxes onto a rack. Reports indicate the patient grabbed the rack in an effort to avoid falling, and experienced severe neck pain with radiating pain to the right arm, and also pain radiating from the low back to both lower extremities. The patient was treated at initially, and has not returned to work.

Records do not indicate who her current treating doctor is, but do show that she was recommended for surgery by Dr. a neurological surgeon, on April 1, 2008. She has not returned to work, and her work status is listed as that she has not achieved the PDL necessary to return to work at her previous job description. She has been given diagnoses of lumbar radiculopathy, lumbar sprain/stain, thoracic sprain/strain, lumbar stenosis, cervical sprain/stain, muscle spasms, herniated disk of the cervical spine at C3-4, C5-6, and C6-7, radicular pain to the right arm, secondary to herniated disc, post traumatic, herniated disc L4-5 and small herniated disc L5-S1. Patient currently takes Ibuprofen 800 mg.

Although the records regarding patient history are scant, patient has been given MRI's, which were positive, and does appear to have received some chiropractic treatment. The surgery requested by the neurological surgeon was denied by the insurance company. Patient was approved for, and has participated in 6 IT sessions, decreasing her pain level from 8/10 to 6/10. Patient has been referred for CPMP, and that is the subject of this request.

Patient was evaluated on 9/9/08, where they found the following: increased crying episodes, memory problems, feelings of hopelessness, feelings of panic, anhedonia, easily angered, changes in appetite, panic attack, headaches, etc. She reports, and FCE showed, decreased ADL's to include reduced driving tolerance, sitting and standing tolerance, walking tolerance, and household chores. On a scale of 1-10, patient rated a 10/10 for the following: money problems, worried, sadness, depression, and sleep problems. She rates the following things an 8 or 9/10: anxiety, anger, irritability, frustration, muscle tension, and memory problems. She rated her pain as 6/10. She was diagnosed with pain disorder and mixed adjustment disorder and recommended for a twenty day chronic pain management program. The goals to be achieved are: increase GAF from 58 to 80, increase cardio tolerance from 5 to 25 minutes, decrease BDI from 30 to 6, decrease BAI from 35 to 10, decrease pain from 6/10 to 1/10, increase sleep form 5 to 9 hours, increase activity levels from 1 to 8 hours, and increase tolerance for strengthening exercises from 5 to 25 minutes.

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

Patient has continued pain complaints, and has received evaluations from her treating medical doctor, a referral specialist surgeon, and a psychotherapist all of whom agree patient is not currently at MMI. Previous methods of treating the pain have been unsuccessful, and patient has been denied surgery. Patient appears to have followed all doctor recommendations to this point, has showed progress with a stepped-care approach, and reports motivation to continue to follow recommendations that would improve her so she can go back to work.

Per ODG, patient 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. The denial based on “records reflect ... discussion of cervical surgery” would usually be appropriate, except that surgery has been denied in this case, as the peer reviewer should have known. The patient is therefore in the tertiary stage of treatment, and could benefit from a return to work program such as the one being requested.

TDI-DWC has adopted the ODG treatment guidelines as the standard for non-network workers' compensation claims. Based on ODG criteria, the current request is deemed medically reasonable and necessary. 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.

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. ([WCRI, 2005](#)) ([Joling, 2006](#)) ([PERI, 2005](#)) ([Smith, 2001](#)) ([Stover, 2007](#)) Delayed recovery has been associated with delayed referral to nurse case management. ([Pransky, 2006](#))

**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 KNOWLEDGBASE
- AHCPH- 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)**