

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 10/15/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5x2

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

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 9/11/08 and 9/3/08

Records 6/12/08 thru 9/11/08

FCE 8/13/08

Records from Dr. 6/24/08 and 8/5/08

Record from Dr. 12/17/08

Records from Dr. 2/27/08 thru 5/21/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was performing his usual job duties when he was injured on xx/xx/xx. Records indicate he was pushing a case of paper into a truck when he felt a sharp pain in his cervical area. Patient went to the company doctor the next day, where records indicate he was evaluated, given pain medications, and returned to work, with restrictions. It is not clear how long he remained at work, but cervical spine surgery was accomplished on 4/29/05. It appears patient has been off work since that time.

Over the course of his treatment, patient has received diagnostics, physical therapy, cervical spine surgeries x 3 (2005, 2006, 2007), post-surgical physical therapy, psychological evaluation, chronic pain management program, and medications management, all with little improvement in pain. History and physical done on 06-24-08 showed chief complaints to involve "a sharp, stabbing pain that sometimes radiates to the chest, sometimes radiates laterally to the shoulder blades, frequently goes down both arms, and involves his third and fourth fingers bilaterally. He presents for admission to a chronic pain program after being deemed a poor candidate for additional surgery due to his cardiac status." Present medications include Hydrocodone, Topamax, Temazepam, Tinazidine, Lyrica, Trazadone, Levaquin, and Warfarin. He is diagnosed with chronic cervical, thoracic, and lumbar pain.

On 06-12-08, patient was evaluated for a chronic pain management program. Patient reported his average pain level at 9/10, with medications, and reported intermittent elevations to 10/10. He rated his pain interference as a 10/10 with regard to the following activities: recreational, social, family, normal, and work. Present coping strategies for pain were not reported. BDI was 61/63 and BAI was 39/63. He reports his pre-injury level of functioning at 100% and current level at 0%. On a scale of 1-10, patient rates himself a 9 or 10 with regard to the following: irritability, frustration, family, job, and money problems, muscular spasm, nervousness, sadness, sleep disturbance, and poor concentration. Mental status exam showed dysthymic mood and constricted affect. Suicidal ideation was present, with no plan or intent.

Patient was diagnosed with pain disorder and major depressive disorder. The current request is for the first ten days of a chronic pain management program. Goals are to reduce severe depression and anxiety to the mild-moderate range with cognitive-behavioral and relaxation interventions, increase patient self-management skills, increase the patient's involvement in ADL's, improve sleep from 5 hours to 8 hours per night, and reduce subjective pain intensity.

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

Although the psychological report suggests that the expected clinical response and prognosis for the patient is good, it does not assess contraindications such as patient's ability to benefit only marginally from previous interventions, failed surgeries, a previous chronic pain program, inability to benefit from physical therapy to increase his PDL's, continued high pain reports despite medications, and overall reported severe levels of depression, pain, and physical and emotional functioning.

Studies from ODG show that pain perception at or above 8/10 is a negative predictor of success in chronic pain programs. There has also been no attempt at moderating some of the extreme pain and depression scores with individual therapy in order to stabilize the patient and assess patient compliance and ability to benefit from intervention.

Therefore, since negative predictors to success have not been examined or addressed yet, the current request is not deemed reasonable or medically necessary at this time.

Productive Rehabilitation Institute of Dallas for Ergonomics (PRIDE) Research Foundation, 5701 Maple Avenue, Dallas, TX 75235, USA.

BACKGROUND: Pain intensity is one of the most widely used measures in the treatment of patients with chronic disabling occupational musculoskeletal disorders. Few studies have comprehensively investigated the relationship of pain intensity at the time of rehabilitation to objective socioeconomic outcomes at one year after treatment. This study evaluated the ability of pain intensity ratings, measured with a visual analog scale, to predict rehabilitation outcomes and to identify patients who are "at risk" for a poor outcome. **METHODS:** A cohort of 3106 patients with chronic disabling occupational musculoskeletal disorders in a multidisciplinary occupational tertiary rehabilitation program was divided into four groups on the basis of the pain intensity ratings (0 to 3, 4 to 5, 6 to 7, and 8 to 10) before and after rehabilitation. A structured interview to assess the socioeconomic outcomes, including work status, health-care utilization, recurrent injury, and whether there had been resolution of Workers' Compensation or third-party financial disputes, was conducted one year after rehabilitation. **RESULTS:** High pain intensity before rehabilitation was linearly associated with declining rates of program completion and higher rates of self-reported depression and disability after rehabilitation. Although higher pain ratings both before and after rehabilitation were associated linearly with a declining quality of socioeconomic outcomes, extremely high pain ratings (8 to 10) after rehabilitation were most predictive of poor outcomes. At the post-rehabilitation evaluation, patients with extreme pain were far more likely than those with mild pain to seek surgical treatment (risk ratio = 11.2 [95% confidence interval, 4.3, 29.5]) or to persist in seeking health care from new providers (risk ratio = 3.3 [95% confidence interval, 2.4, 4.5]). They were less likely to either return to work (risk ratio = 3.9 [95% confidence interval, 2.6, 6.0]) or to retain work (risk ratio = 4.2 [95% confidence interval, 2.9, 6.0]). They were also twice as likely to claim a new injury to the same musculoskeletal site after returning to work and to fail to settle Workers' Compensation or third-party financial disputes. **CONCLUSIONS:** High pain ratings before rehabilitation are associated with higher rehabilitation dropout rates. The patients with chronic disabling occupational musculoskeletal disorders who reported extreme pain after completing a full course of extended treatment (13% of 2573) were at risk for poor outcomes in terms of lost productivity, high utilization of health care, and cost-shifting of state Workers' Compensation payments to federal resources.

Aetna Clinical Policy Bulletins. Chronic Pain Programs Number 0237. Reviewed: May 5, 2006.

Aetna considers a screening examination medically necessary for members who are being considered for admission into a chronic pain program.

MMPI: Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain. The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the patient's levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain patients:

- *Conversion V profile*: An elevation of scores on the hypochondriasis scale (scale 1, Hs) and hysteria scale (scale 3, Hy), with at least 10 points greater on these scales than on the depression scale (scale 2, D). Evidence of this profile has been interpreted as evidence of a preexisting personality that is a major contributing factor in chronic low back pain, although this is disputed. Elevations of hypochondriasis (scale 1) and hysteria (scale 3) have been found to negatively correlate with return to work.

- *“Neurotic triad”*: has been coined to describe a cluster of elevated scores of hypochondriasis, depression and hysteria. Evidence has been supportive that these scales are consistently elevated in pain patients, predicting both decreased short- and long-term pain relief. Evidence has also been found to be conflicting as to whether scales 1 and 3 are associated with functional impairment related to pain.

- *PAIN*: A clustering of pain scales based on the MMPI that was described by Costello, et al., including the following: P: Nearly all scales are elevated; A: The Conversion V profile; I: The “neurotic triad”; & N: Normal.

Criteria for Use of the MMPI:

- (a) To determine the existence of psychological problems that are comorbid with chronic pain;
- (b) To help to pinpoint precise psychological maladjustment and help to tailor treatment;
- (c) To garner information that may help to develop rapport and enhance level of motivation;
- (d) To detect psychological problems not discussed in the clinical interview. One particular area that may be helpful is the use of the Addiction Acknowledgement Scale.

([McGrath, 1998](#)) ([Ruchinskas, 2000](#)) ([Slesinger, 2002](#)) ([Chapman, 1994](#)) ([Trief, 1983](#)) ([Arbisi, 2004](#)) ([Vendrig, 2000](#))

Psychological evaluations: Recommended. *Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations.* Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. ([Main-BMJ, 2002](#)) ([Colorado, 2002](#)) ([Gatchel, 1995](#)) ([Gatchel, 1999](#)) ([Gatchel, 2004](#)) ([Gatchel, 2005](#))

Cognitive therapy for depression: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps

to keep patients in treatment. ([Pampallona, 2004](#)) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ([Royal Australian, 2003](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. ([Warren, 2005](#))

ODG Psychotherapy Guidelines:

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

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.

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](#)

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](#))

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)**