

P-IRO Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 09/05/08

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

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 8/4/08 and 7/25/08

Records from St. : 12/19/07 thru 7/28/08

Records from : 1/21/08 thru 3/24/08

DDE 5/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who sustained a work-related injury on xx/xx/xx. Patient was performing his usual job duties as a , when he was thrown 15 feet of a well platform, subsequent to an explosion involving a pressure cap, injuring his face and skull. He was taken to the ER, and diagnosed with fracture to the right orbit. He also sustained damage where skin was torn from his forehead, revealing bone, which necessitated reconstruction involving 80 stitches. The fracture was fixed by open reduction and internal fixation. He

received chest x-rays, CT scan, an MRI, and released. Three days later, patient followed up with a treating physician, who additionally diagnosed that his right arm had been injured, and splinted the arm. He referred the patient for a psychiatric consult, orthopedic eval, and home health care.

Subsequent to the explosion, patient has received numerous evaluations and interventions to include: x-rays, MRI's, FCE, and has been treated conservatively and secondarily with surgery, physical therapy, medication management, and individual therapy, with no overall improvement in his pain. He received additional diagnoses of right ulnar distal fracture, PTSD, depression, headaches, neuropsychological problems, head trauma, transverse ulnar fracture, C6 radiculopathy, herniated L5-S1 disc, annular tear, and C5-C6 disc protrusion. Additional cervical and lumbar surgeries were recommended in 2007, and these appear to have been initially denied by the insurance company. Medication management has included Lexapro, Naprosyn, Vicoden, Soma, and Robaxin. Patient received a 22% impairment rating and designated doctor recommended multidisciplinary CPMP.

Patient was approved for, and has received, 10 days of a multidisciplinary chronic pain program, and this request is for an additional 10 days of the program.

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

Patient has continued pain subsequent to being in an explosion, and has received evaluations from his treating medical doctor, a psychotherapist, psychiatrist, and independent medical examiner, 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 currently 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 he can go back to work. He even has volunteered in a nursing home, despite his numerous difficulties. 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 has not been discussed with the patient.

Patient was apparently denied for the second half of the program for lack of progress, but this is not the case. Patient has actually made good progress in all areas assessed, and given his multiple injuries and high impairment rating, seems to qualify for outlier status and may require more than the customary 20 sessions. Patient's BDI and BAI have improved, coping strategies have increased, VAS pain scores have decreased, sleep is improved, and physical conditioning is improving overall. Patient has decreased his narcotic medications schedule and is considering vocational options to included becoming licensed as a chemical dependency counselor.

Per ODG, patient has followed a stepped-care approach to treatment, and is now in the tertiary stages of his treatment. Therefore, the current request for the second 10 days of his program is deemed medically reasonable and necessary, per ODG criteria. 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 for 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:**

- 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)