

# True Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** 09/07/08

**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 8/6/08 and 8/13/08

Records from 12/4/07 thru 8/22/08

Letter from Dr. No Date

PPE 6/23/08 and 12/13/07

Records from Dr. 1/3/08 thru 4/24/08

FCE 3/6/08 and 1/15/08

Record from Dr. 2/11/08

MRI 12/7/07

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

The claimant is a xx year-old female who sustained a compensable, work-related injury to her low back on xx/xx/xx. Patient was performing her usual job duties as a for , when records indicate she slipped and fell on a greasy floor, landing on her left hip and buttocks. She felt immediate pain, and initially sought attention from the local emergency room, where she was evaluated, given x-rays, medications, and told to follow-up with a physician. Patient then sought care from Clinic. Since this time, patient has not returned to work.

Over the course of her treatment, patient has received x-rays, lumbar MRI, physical therapy, psychological evaluations, 4 individual therapy sessions, 10 days of work hardening program, numerous FCE's, trigger point injections, and medications management. MRI conducted on 12/7/07 revealed mild disk bulge at L5/S1 without spinal canal stenosis or foraminal narrowing. Patient was diagnosed with strain/sprain syndrome of the lumbar spine via a neurology consult.

Patient was approved for, and has attended, four sessions of individual therapy, beginning on 12/07/07. Patient presented with BDI score of 30 and BAI score of 24, and was given a diagnosis of pain disorder associated with both psychological factors and a general medical condition, and adjustment disorder with mixed anxiety and depression. Patient also attended 10 sessions of Work Hardening program during April of 2008. On July 17, 2008, a request was made for the first ten days of a chronic pain management program, and that request is the subject of this review.

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

Report states "the client continues to suffer from problematic symptoms, disabilities, and other negative issues resulting from her work-related injury." Current medications were listed as none, although report states that one of the goals for this patient is to "reduce her reliance on medications..." Current average pain level is a 4/10 on an intermittent basis, down from a constant 9/10 immediately post-injury. Patient is reported to currently be sleeping a full 8 hours per night, increased from 5 hours prior to individual therapy. Likewise, pain interference in work/social situation had decreased from 8/10 to 6/10, subjectively. Other important gains made by patient that appear to have generalized, given the length of time from her WH program, would be an increase in standing tolerance, walking tolerance, and driving tolerance. Curiously, her sitting tolerance has decreased from 2 hours to only 40 minutes. BDI had decreased from the severe to the moderate range, and BAI had also decreased from 24 to 21. Mental status exam notes nothing abnormal, and GAF was 60. There is no other formal testing to substantiate claims made in the report regarding the patient's "disabilities", "poor coping skills", etc.

There are also no specific descriptions in any of the numerous FCE's of the required PDL for a demo associate, and no tracking of whether she now meets or

exceeds this benchmark. Additionally, there are no explanations regarding the numerous times patient evidenced suboptimal performance on FCE validity measures. There is also no discussion about why the original request for 4 sessions of IT was not extended, since it appears patient may have been responding positively. Additionally, many of the remarks made in this request are referenced to a male, versus a female, so one can only assume that all the statements are accurate.

ODG states that, to be approved, previous methods of treating the chronic pain have to have been unsuccessful and there must be an absence of other options likely to result in significant clinical improvement". It appears that patient has improved over time and may be able to work at least a 6 hour day, given that she reports being able to sustain this level of activity, and given that she has exceeded the ODG RTW guidelines for her diagnosed strain/sprain. Additionally, it appears that a complete "stepped-care approach", as prescribed by ODG, was never followed, given the limited number of individual therapy sessions that this patient received.

Given the above, request cannot be established as medically reasonable and necessary.

**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](#)) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. ([Gatchel, 1999](#)) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. ([Goldberg, 1999](#)) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. ([Linton, 2002](#)) Other studies and reviews support these theories. ([Perez, 2001](#)) ([Pulliam, 2001](#)) ([Severeijns, 2001](#)) ([Sommer, 1998](#)) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. ([Lin-JAMA, 2003](#))

See "[Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients](#)" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25)

Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale – VAS. ([Bruns, 2001](#)) See also [Comorbid psychiatric disorders](#). See also the [Stress/Mental Chapter](#).

**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:**

- 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)