

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 18, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed chronic pain management program X 10 sessions

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
845.10, 718.97, 726.10	97799		Prosp	10					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- an estimate of 650 pages of records received to include but not limited to: PHMO notice; Health records, 1.19.07--2.9.09; DDE 2.19.09, DWC forms 69; review of medical history, Physical exam, IR report on date 10.14.08 and 2.19.09; MMI report 6.26.08, 2.9.09; letters 12.6.06-2.4.09; progress assessment, Dr. 12.17.08, 1.8.09; records Dr. , 8.23.08-12.6.08; NCV/EMG report 12.9.08; Surgical report 8.14.08-8.27.08; RME 2.25.08, 7.17.08, 10.14.08, 12.3.07, 8.6.07; Healthcare records 11.27.06-6.14.07; Orthopedics records 3.12.08-7.9.08; B &W Medical supplies records; MRI Lft Ankle 6.10.08; progress report, 1.28.08-2.28.08; records, Dr. 3.12.08; xrays l-spine 8.9.07; report, Health Systems 1.24.08; CT post Myelogram 9.20.07, 10.16.07; Injection and Diagnostics report 4.9.07-6.8.07; records Dr. 8.1.07; DDE 3.2.07; records, Dr. 2.12..07-6.8.07; FCE 3.22.07,6.14.07; PPE 1.5.07, 4.24.07; MRI LFT ankle 12.16.06; MRI L-spine 12.16.06; Injury Management Associates records 11.29.06; email from 12.6.06

Respondent records- an estimate of 53 pages of records received from the URA to include but not limited to: Health records 1.9.09-2.4.09; Letters 1.9.09, 2.4.09; Healthcare and Rehabilitation patient information sheet; progress assessment notes 1.9.09, Dr. IRO assignment

Requestor records- a total of 66 pages of records received to include but not limited to: Fax confirmation sheets; Health records 1.28.08-2.9.09; request for an IRO forms; Letters 1.9.09, 2.4.09; Healthcare and Rehabilitation patient information sheet; progress assessment notes 1.9.09, Dr. ; report Dr. 11.8.08; MRI Lft Ankle 12.15.06; MRI L-spine 12.15.06

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a compensable, work-related injury to his low back and ankle on xx/xx/xx. Patient was performing his usual job duties as an employee when records indicate the tipped over, causing injury to the low back and ankle. Patient was apparently fired from this job position, and has subsequently sought help for his injuries. Patient was taken off work and remains in an off-work status at the current time. He desires to return to a job as a, which is his present skill set. This would require a return-to-work PDL of Heavy.

Over the course of his treatment, patient has received x-rays, lumbar MRI's, active physical therapy, psychological evaluations, work hardening program (2 weeks), injections, ankle surgery (8/14/08), 20 days of CPMP, and medications management. MRI of 12-15-06 revealed 3-4mm disk protrusion at L3-L4 that minimally indents the thecal sac and a 3-4 mm disc protrusion at L4-L5 that mildly indents the thecal sac. Patient has been diagnosed with lumbar radiculitis, lumbar disc displacement, lumbar mechanical low back pain, lumbago and chronic pain syndrome. His current medication is Ibuprofen 800mg 1 prn breakthrough pain.

Patient was approved for, and has attended, 20 days of a CPMP. The current request is for an additional 10 days of CPMP. Report indicates that patient has made the following progression: reduction of narcotic medication usage (Darvocet N-100 and Lyrica have been discontinued), reduction in depression, (BDI decreased from 13 to 8), improved sleep, decreased frustration level, and improved PDL from the Light to Medium/Heavy range. Goals for the last 10 days of the program are to focus on: achievement of the required RTW Heavy PDL, decreased pain and anxiety symptomatology, and a concretized vocational plan to return patient to his previous job as a with a new employer. Report states "he must be approved to complete the program in order to extinguish active symptoms, increase his functional ability, and to propel him towards a safe return to work."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S

**POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES,
THEN INDICATE BELOW WITH EXPLANATION.**

Per records, over the first twenty days of the program, patient has been able to significantly increase his functioning despite continued high pain levels. His PPA shows that he has improved his leg lifting ability to 32.4 pounds (a 60% improvement), improved his arm lift ability to 35.6 pounds, improved his average lifting tolerance from 15 pounds to 35 pounds (goal is 75 pounds), and improved carrying tolerance from 15 to 35 pounds, also with goal of 75 pounds. Overall, report indicates he is functioning in the Medium/Heavy range, but still needs to meet functional goals of: performing ADL's, lower extremity exercises, and work activities with decreased complaints of pain, guarding, bracing, fear, and self-limiting behavior. Lifestyle alterations as well as psychosocial self-reports also seem to have improved, and report indicates patient is motivated to return to work in his previous job title with a different employer. Mental status is also reportedly improving, and patient has completely discontinued opiate use. Although "pain", "irritability", and "frustration" still are in the moderate ranges, these are one-word descriptors and are not included in ODG's recommended list of standardized testing. Additionally, with a functional restoration program, functioning is emphasized despite pain. Although this is a difficult call, it would appear that patient is motivated to return to work in the same or a related field, but has not plateaued and still has functional and behavioral goals to meet. Discontinuation at this point could mean the difference between continued disability and off-work status or productive participation if the workforce for this patient. ODG states that "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved". It is reasonable to believe that patient's functional RTW goals can be achieved. As such, this request is deemed reasonable and necessary per TDI-DWC and ODG.

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.](#)

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](#).

Comorbid psychiatric disorders: Recommend screening for psychiatric disorders.

Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). ([Dersh, 2006](#)) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. ([Dersh, 2002](#)) See also [Psychological evaluations](#).

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](#))

Chronic pain programs; ODG Pain section, 2009: Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), 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 & occupational 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](#)) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders.

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 treatment; (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](#)) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. ([Buchner, 2007](#))

Timing of use: Early intervention is recommend (3 to 6 months post-injury) depending on identification of patients that may benefit from early intervention via a multidisciplinary approach. See [Chronic pain programs, early intervention](#). The probability of returning to work for those out over two years may be less than 1%, if such patients are not offered quality, comprehensive interdisciplinary functional restoration programming. In a high-quality cohort study, the short-term

disabled group (4-8 months post-injury) achieved statistically higher RTW compared to the long-term disabled group (> 18 months post-injury), suggesting that early use of a functional restoration program is efficacious, but individuals with long-term disability still achieved respectable RTW justifying use of the program. ([Jordan, 1998](#)) ([Infante-Rivard, 1996](#)) ([TDI, 2007](#)) See also [Chronic pain programs, intensity](#); [Chronic pain programs, opioids](#); [Functional restoration programs](#); & [Chronic pain programs, early intervention](#).

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) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
- (2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
- (3) 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;
- (4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided;
- (5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note [functional and psychological improvement](#);
- (6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;
- (7) Negative predictors of success above have been addressed;
- (8) These programs may be used for both short-term and long-term disabled patients. See above for more information under *Timing of use*;
- (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures 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;
- (10) Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;
- (11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury.

FRP's: Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see [Chronic pain programs](#)), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. ([Bendix, 1998](#)) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. ([Guzman 2001](#)) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. ([Airaksinen, 2006](#)) 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](#)) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see [Chronic pain programs](#).

Functional improvement measures	<p>Recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement. It should include the following categories:</p> <p><i>Work Functions and/or Activities of Daily Living, Self Report of Disability</i> (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.)</p> <p><i>Physical Impairments</i> (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees.</p> <p><i>Approach to Self-Care and Education</i> Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007)</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES