

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 31, 2011

**IRO CASE #:**

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

Medical necessity of proposed 10 sessions of chronic pain management (97799)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

### **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
724.4	97799		Prosp	10					Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-19

Respondent records- a total of 259 pages of records received to include but not limited to: peer review 2.23.11; Injury Center of records 9.7.10-8.31.11; records 9.23.10-9.23.11; Pain Consultants 11.4.10-12.16.10; MRI Lumbar Spine 10.13.10; Dr., operative report 11.30.10; Dr.

records 10.29.10-1.28.11; records 12.22.10; FCE 1.26.11; DWC 59 5.23.11; DDE report 5.23.11; MRI Cervical Spine 2<sup>nd</sup> opinion 1.21.11; IRO report 5.2.11; URA notes 7.28.10-5.211

Requestor records- a total of 29 pages of records received to include but not limited to: records 8.17.11-10.11.11; Injury Center of note 8.31.11

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

The medical records presented for review begin with a copy of the non- certification of the above listed request. It was noted that the request had previously been non-certified as there was insufficient clinical data to support the request. It is also noted that the injured employee made minimal progress with the additional interventions and had poor coping skills, anxiety, depression and chronic pain complaints. This lack of coping led to the determination that additional chronic pain management was not reasonably required.

Another review was completed by Dr. a PhD psychologist, who noted the date of injury, treatment to date, the lack of improvement, and that the claimant was determined to be at maximum medical improvement with a 0% whole person impairment rating.

I then reviewed the bulk of the medical records again, and a peer review completed by Dr. on February 23, 2011. This review noted that the claimant is a man who sustained an injury while working as a. The reported motor vehicle accident was a rear end collision. It is noted that the accepted compensable injury was limited to a sprain/strain of the cervical and lumbar spine only. The care included an initial clinical evaluation and subsequent treatment by a chiropractor. There were ongoing complaints of back pain treated with multiple medical interventions and medicine protocols. It was noted that multiple sessions of physical therapy were completed with no real improvement in the overall symptomology.

A cervical spine MRI noted disc pathology at C4/5, C5/6, and C6/7. A lumbar MRI noted multiple levels of disc pathology from L3 through S1. An evaluation from Dr. noted multiple level degenerative changes and vertebral disc derangement with a possible radiculitis; epidural steroid injections were suggested. It was noted that an epidural steroid injection was completed, and a 75% improvement was noted. A second opinion of the MRI studies noted significant degenerative changes and osteophytic spurring throughout the cervical and lumbar spine. After completion of this, Dr. did not endorse the treatments that were being delivered.

In August 2010, D.C. evaluated the claimant and felt that additional chiropractic and physical therapy modalities were indicated. Dr. endorsed injection therapies after this evaluation, as none of the interventions had been successful. A repeat MRI lumbar spine was obtained on October 13, 2010, noting disc bulges, significant degenerative changes, disc desiccation and arthritic findings.

Multiple additional chiropractic interventions are noted. A functional capacity evaluation is completed. D.C. completed an intervention on January 28, 2011, and noted that there was some improvement as per the FCE. However, the second page of his report notes that the pain level went from 6/10 to 5/10 and that there were still symptoms of pain and anxiety. A subsequent study reported the injured employee as having a "severe disability".

A behavioral evaluation was completed at the center. It is noted that ten sessions of CPMP had been completed. Psychotherapy had been completed and minimal progress was reported. No improvement was noted with the functional testing.

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

### **RATIONALE:**

As noted in the Division mandated Official Disability Guidelines Pain Chapter, Updated October 21, 2011, there are conditions to be met prior to any such program. These are:

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 have resulted in "[Delayed recovery](#)". There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), 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](#)) 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](#)) See [Biopsychosocial model of chronic pain](#).

### ***Types of programs:***

(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.

***Outcomes measured:*** Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to "demedicalize" treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See [Opioids for chronic pain](#).)

### ***Outcomes (in terms of body parts)***

Multidisciplinary back training: (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the “graded activity” principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year’s duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment. ([van Geen, 2007](#)) ([Bendix, 1997](#)) ([Bendix, 1998](#)) ([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

Intensive multidisciplinary rehabilitation of chronic low back pain: The most recent Cochrane study was withdrawn from the Cochrane (3/06) as the last literature search was performed in 1998. Studies selected included a physical dimension treatment and at least one other treatment dimension (psychological, social, or occupational). Back schools were not included unless they included the above criteria. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function when compared to inpatient or outpatient nonmultidisciplinary rehabilitation. Intensive (> 100 hours), daily interdisciplinary rehabilitation was moderately superior to noninterdisciplinary rehabilitation or usual care for short- and long-term functional status (standardized mean differences, -0.40 to -0.90 at 3 to 4 months, and -0.56 to -1.07 at 60 months). There was moderate evidence of pain reduction. There was contradictory evidence regarding vocational outcome. Less intensive programs did not show improvements in pain, function, or vocational outcomes. It was suggested that patients should not be referred to multidisciplinary biopsychosocial rehabilitation without knowing the actual content of the program. ([Guzman, 2001](#)) ([Guzman-Cochrane, 2002](#)) ([van Geen, 2007](#)) ([Bendix, 1997](#)) ([Bendix, 1998](#)) ([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested. ([Karjalainen, 2003](#))

In this case, there is no objectification of any motivation to improve, there is no data about the efficacy of that program, and the utility of prior interventions have proven for naught. This is not recommended.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- 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