

P&S Network, Inc.

P.O. Box 48425, Los Angeles, CA 90048

Ph: (310)423-9988 Fx: (310)423-9980

Notice of Independent Review Decision

DATE OF REVIEW: December 5, 2007

IRO CASE #:

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

This case was reviewed by a PM & R Specialist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten sessions of chronic behavioral pain management

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree with prior noncertifications)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o April 18, 2006, Chiropractic Report, DC
- o May 4, 2007, Psychological Evaluation, Mr. LPC
- o June 29, 2007, Evaluation Report, Illegible Signature
- o July 25, 2007, Treatment Summary, LPC Intern
- o July 27, 2007, Functional Capacity Evaluation, Dr.
- o September 18, 2007, Psychological Reevaluation, Ms. LPC Intern
- o September 20, 2007, Peer Review Report, Dr.
- o October 10, 2007, Appeal Chronic Behavioral Pain Management Program Report, Ms. LPC
- o October 18, 2007, Peer Review Report, Dr.
- o November 20, 2007, Letter from Attorney,
- o November 21, 2007, Letter from RN

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury to his lumbar spine. The patient underwent a lumbar spine fusion in 1998 and in 2002. Treatment has included injections, physical therapy, and a TENS unit. Additionally, the patient was in a work hardening program for two weeks, which did not improve his condition.

The patient underwent a psychological evaluation with a Licensed Professional Counselor on May 4, 2007. The patient was diagnosed with a chronic pain disorder with both psychological features and a general medical condition. The patient had a Beck Anxiety Inventory Score of 10 and a Beck Depression Inventory Score of 2.

It is interesting to note that upon reevaluation on July 25, 2007, after the completion of five sessions with a Licensed Professional

Counselor, the patient's Beck Anxiety Inventory Score was 9 and the Beck Depression Inventory Score was 5. This would not equate to significant improvement. In fact, the patient's depression score deteriorated by three points.

The patient underwent a Functional Capacity Evaluation on July 27, 2007. Recommendation was given at that time for a full psychological evaluation and 10 sessions of chronic pain management followed by a second Functional Capacity Evaluation. It should be noted that the patient had already completed five psychological visits before the FCE.

The initial peer review performed on September 20, 2007 rendered a non-certification determination for a chronic pain management program as the patient had already participated in four sessions of individual psychotherapy. He further noted that the patient had progressed physically, however, continued to suffer from bouts of depression as well as increased stress due to lost finances and changes and his daily activities secondary to his pain.

A letter of appeal was submitted by the treating Licensed Professional Counselor on October 10, 2007. She noted that individual counseling was failing to provide a multidisciplinary approach. She notes that the patient's sleep patterns have remained poor and his activity levels remain low with an overall global functioning GAF of 60. She stated that a chronic pain management program would provide a more intense environment and allow for further introduction to cognitive behavioral techniques, while also adding daily physical rehabilitation. She reported that objectively, the patient demonstrated continued deficits in lumbar range of motion, strength and endurance. However, these findings were not objectified in the form of a physical examination.

This was sent to peer review on appeal, and again, a non-certification determination was issued. The peer reviewer noted that there was no updated objective assessment of functional abilities and/or limitations. There was no documentation to support therapeutic benefit of an interdisciplinary program for chronic pain syndrome.

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

As noted in the Official Disability Guidelines, there are six criteria which must be met in considering this type of pain management program. Specifically, one of the criteria states that the patient must have a significant loss of ability to function independently resulting from the chronic pain. As noted above, the medical records fail to document a thorough physical examination indicating the patient's objective functional deficits. According to a report dated September 18, 2007, the patient has already returned to work part-time. Clearly this would indicate that the patient is functioning. Consequently, the medical records fail to document a significant loss of ability to function independently, and therefore, he does not meet the criteria for this type of program.

Additionally, the medical records fail to document evidence of functional improvement with prior psychological treatment. Participation in a chronic pain management program that incorporates psychological participation would not be any different for this patient. The medical records fail to document the medical necessity of further psychological treatment.

Furthermore, the patient had already participated in a work hardening program which did not improve his condition. Again, it would not be advisable to reinstate the patient into a formal treatment program that did not improve his condition previously.

Therefore, recommendation is to uphold the prior noncertification for 10 sessions of a chronic behavioral pain management program.

The IRO's decision is consistent with the following guidelines:

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

X 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

Official Disability Guidelines, 2007. Chronic pain programs may be 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.

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) (Gatchel, 2005)

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 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.

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)