

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 28, 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 Pain Management doctor, 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 a chronic behavioral pain management program

REVIEW OUTCOME

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

Upheld (Agree)

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 November 21, 2007 peer review report from
- o October 30, 2007 notification of determination from
- o November 26, 2007 request letter from, Ph.D., LCSW
- o October 8, 2007 evaluation report by, M.S., LPC
- o November 8, 2007 request for an appeal by, M.S., LPC
- o October 8, 2007 physical performance evaluation report from Diagnostics
- o October 15, 2007 narrative report by, LPC
- o June 2, 2006 report by, M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. An October 30, 2007 peer review report rendered a non-certification for a chronic pain management program five times a week for two weeks for the lumbar spine. The report states that the patient continues to complain of low back pain, status post two prior back surgeries. The patient has completed physical therapy, received three epidural injections, chiropractic treatments, electrical muscle stimulation, massage, stretching, and acupuncture without relief. He has completed three prior individual counseling sessions to date. A Beck Anxiety Inventory revealed mild anxiety and a Beck Depression Inventory revealed mild depression. The peer review physician stated that the claimant has not responded to any conservative care to date. Based on the clinical information submitted for the review and using the evidence based, peer-reviewed guidelines, the request is not indicated. The report referenced the Official Disability Guidelines.

An appeal letter was submitted dated November 8, 2007. The letter addresses the peer review reports assessment that the claimant has not responded to conservative care to date. The appeal letter states that a physical performance evaluation of October 8, 2007 compared to that done on November 13, 2006 showed improvements, although progress has been slow. Left hand grip strength has reportedly improved from 10 pounds to 45 pounds and slow gains have been seen in strength. The letter

states that according to the Official Disability Guidelines, a criterion is that previous methods of treating chronic pain have been unsuccessful. The letter states that the patient continues to experience chronic pain that interferes with his physical, psychological, social, and occupational functioning and deserves the opportunity to participate in the program that can improve functional restoration from a multidisciplinary perspective. He continues to experience chronic pain rated at a 7/10 and a 15 on the McGill Pain Questionnaire. His low back pain radiates down into the right lower extremity. He presents with very limited coping strategies to manage the symptoms and used inactivity as his primary pain management strategy. He presents with mild symptoms of depression and anxiety as well as sleep disturbance that were not present pre-morbidly. The psychological portion of the proposed program will focus on introduction to a variety of strategies to manage pain complaints while improving daily activity levels. A letter states that the patient has exhausted multiple treatments, including conservative psychotherapy, and is not ready for a tertiary level of care focused on improving function despite his pain. Psychological stressors can predict a negative outcome to such a program according to the letter and the patient's symptoms did not appear to be of a severity that would hinder his progress in such a program. The program is to focus on cognitive behavioral therapy, group therapy, coping skills, biofeedback, and continued physical therapy which will allow him to function more independently both physically and cognitively according to the letter.

A noncertification was rendered again on November 21, 2007 by another peer reviewer. The reasons provided is that the patient did not currently require the intensity of the chronic pain management program. The report notes that the patient has minimal anxiety and depression and pain is not an issue, as the patient is not currently taking medication.

An October 15, 2007 report from the requesting party addresses each of the Official Disability Guidelines criteria. Regarding the criterion that states that the patient must have a significant loss of ability to function independently resulting from the chronic pain, the report states that according to the psychological evaluation, the patient is unable to perform household chores. In addition, he is unable to participate in recreation and he cannot physically function without pain. The financial stress increases his awareness of the pain. The pain always interrupts his sleep as well. The report notes that the patient is currently not working and is unable to return to work due to his physical disabilities, depression, and anxiety. An October 8, 2007 physical performance evaluation report states that the patient's Oswestry Low Back Pain Disability score was 68% representing a crippled status. According to this disability questionnaire, the back pain impinges on all aspects of the patient's life both at home and at work and positive intervention is required. He was found to be performing at a sedentary/light level and his occupation requires a heavy functioning level.

An October 8, 2007 psychological report states that the patient is currently not taking any medication for the injury, but has in the past. He reports that he sleeps five to six hours per night and reports moderate fatigue. Again, his Beck scores represented mild anxiety and mild depression. The Axis I diagnosis was chronic pain disorder resulting from the work injury of June 24, 2004, no Axis II diagnosis, Axis III diagnosis of resulting from work injury of June 24, 2004, Axis IV diagnosis of occupational problems, economic problems, and educational problems, and Axis V GAF score of 54 and prior to the injury 76.

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

As noted in the references, the Official Disability Guidelines include as a criterion for admission to a chronic pain management program that the patient has a significant loss of ability to function independently resulting from chronic pain. The medical records fail to document such a significant loss of ability to function independently. The patient is noted to only have very mild depression and anxiety. His sleep patterns do not differ greatly from those of the general public. Most importantly, he is noted to not be taking medication for the injury. He has demonstrated an ability to function at a sedentary/light level while his occupation requires a heavy functioning level. This would be more consistent with a necessity for work conditioning without the need for a multidisciplinary approach encompassed within the requested chronic pain management program. However, the patient has had extensive treatment and has been noted to have only improved minimally in terms of function. This calls into question whether the patient would be expected to respond significantly to the proposed chronic pain management program. Therefore, my determination is to uphold the previous decisions to non-certify the request for ten 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:

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. 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) (Gatchel, 2005) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs.

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) See Functional restoration programs.