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DATE OF REVIEW: April 7, 2008

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

10 daily sessions of Chronic Pain Management to be rendered at 8 hours per session

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 January 14, 2007 treatment progress report DOS 11-1-07 to 12-11-07, , MS, LPC
- o February 26, 2007 IME report of Dr.
- o April 27, 2007 evaluation and medical history review of Dr.
- o May 22, 2007 Functional Capacity Evaluation, LOT
- o August 2, 2007 Functional Abilities Evaluation, Dr.
- o December 4, 2007 Enhanced Interpretive Report
- o January 3, 2008 Psychiatric Evaluation report, Dr.
- o January 16, 2008 Preauthorization request for and description of a Chronic Pain Management Program, Dr.
- o January 22, 2008 Adverse Determination letter
- o February 11, 2008 Letter of Appeal, , MS, LPC
- o February 18, 2008 2nd Adverse Determination letter
- o March 10, 2008 request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior review, the patient is a xx-year-old bus driver employee who sustained an industrial injury to the left shoulder, neck and lower back on xx/xx/xx when she slipped on ice and fell.

An Independent Medical Evaluation was provided on February 26, 2007. It was noted that treatment to date included 2 lumbar epidural injections which provided temporary relief. Medications at that time included Celebrex, hydrocodone (Norco), Zanaflex (Tizanidine for muscle spasms) and Nexium (for an intestinal infection). Per reviewed medical records, the patient was recommended to take Cymbalta (duloxetine - for major depressive disorders) 30 mg x 7 days and 60 mg thereafter, as well as to undergo psychological evaluation and biofeedback. A report of May 2007 stated the patient reported Cymbalta was helpful and improves her fatigue. There was no clinical or historical evidence of radiculopathy. It was opined that she has developed a pain avoidance syndrome which is common and often due to psychological factors and other factors. Recommendation was for aggressive active physical therapy. It was opined that Zanaflex is not indicated as there are no muscle spasms. Norco can be addictive and should be tapered. Celebrex has not been shown to be more effective than over-the-counter anti-inflammatory

medications.

Per a second opinion evaluation of April 27, 2007, the patient stated that lumbar injections provided in September of 2006 and March of 2007 were beneficial. Lumbar MRI of January 2006 shows a small L5-S1 disc herniation which may be touching the passing S1 nerve roots. An EMG of February 2006 reportedly shows lumbar radiculopathy. A second opinion evaluator did not corroborate the EMG findings on examination and additional injections were not recommended. Symptom magnification was opined based on a discrepancy of straight leg raising in the sitting and lying position and voluntary restricted range of motion with reference to the hip examination. No significant clinical findings were found in reference to the cervical spine. No diagnosis related impairment was found for the left elbow, shoulder or hip that would be ratable. The patient was felt to be MMI and have a light PDL category which allows for lifting up to 20 pounds and repeated lifting up to 10 pounds. FCE was recommended to determine return-to-work capabilities.

A Functional Capacity Evaluation was performed on May 22, 2007. The patient stated she suffered a crush injury to her leg in 2005 and had a work-related right shoulder injury with continued unresolved issues. The patient demonstrated antalgic gait and would frequently lie down on the exam table for pain relief. The patient's testing places her in the PDL light category.

In August of 2007, she reportedly underwent a lumbar discogram which showed a disc herniation. MMI was determined by a designated doctor. A referral was made to her primary provider for a Functional Capacity Evaluation to determine her ability and assess her candidacy for a chronic pain management program. A Functional Abilities Evaluation was provided on August 2, 2007

A psychiatric evaluation was performed on January 3, 2008. The patient reports continuing back and neck problems as well as depression and anxiety. The patient reports limited help from treatment of physical therapy. Two epidural steroid injections (ESIs) were provided in the lumbar area. The first had no effect and the second injection lasted one or two days. The patient reports continuing pain in the cervical region described as 7/10 in intensity and lumbar pain described as stabbing with pins and needles and a burning sensation into the bilateral lower extremities to the knee. The patient reports depression since the injury. She has lost interest and sees no future. She has lost 25 pounds from loss of appetite and about 60% of her libido. Current medications include Celebrex, Zanaflex, Duragesic patches, Darvocet, Provigil, Hyoscyamine (Levsin-for GI disorders) and Zegerid (omeprazole and sodium bicarbonate for ulcers and heartburn). The patient displays a lot of emphasis on her pain condition and how this situation has changed her life. The diagnosis includes major depressive disorder related to the accident, generalized anxiety disorder related to the accident and psychological factors associated with medical condition. Recommendation is for a chronic pain management program, 20 sessions 4 sessions of medication management including anti-depressant medication such as Cymbalta.

On January 14 2007, the therapist submitted a treatment progress report. The patient was initially provided treatment at a local hospital. Diagnostic studies provided include, x-rays, EMG, discogram in November of 2006, cervical MRI in January 2006 and lumbar MRI in October of 2006, which reportedly shows a minimal annular bulge at L4-5 and a small disc herniation at L5-S1, CT of the lumbar spine in October of 2006, a Functional Capacity Evaluation in February of 2007 and an Independent Medical Examination in February of 2007. The patient reports no change in her marital status or living situation. She wishes to participate in computer classes.

On January 16, 2008 request was made by the provider for pre-authorization of an outpatient chronic pain management program, daily for 10 days, to include physical therapy, pain management, stress management, psychoeducational group, group psychotherapy, individual psychotherapy, biofeedback, occupational/vocational counseling and medical management.

Request for a chronic pain management program of 5 sessions weekly for 2 weeks was non-certified in review on January 22, 2008 with rationale that the patient appears depressed enough to require antidepressant medication, but is not on antidepressant medications. If the patient was on antidepressant medications she would have likely made more major gains and therefore it does not appear that lower levels of care have been exhausted according to the report. This is particularly important because the patient is already functioning at or near the PDC level required for her job. Thus, the critical component of the proposed treatment is really the psychological component, and psychological intervention alone may be sufficient to get the patient so that she can return to work.

On February 11, 2008, the therapist responded to the denial letter of January 21, 2008. This response states that the denial stated that "the patient is functioning at or near the PDC level required by her job level. The psychological component remains to be addressed so that she can return to work. The patient made minor gains in psychotherapy without antidepressant medication and could have made greater gains had she been on antidepressants". The therapist responded that medication management visits were recommended in a psychiatric evaluation of January 3, 2008 and authorization is pending for those visits. In addition, the patient was prescribed Cymbalta in 2006. Individual counseling gains are evidenced by her reduction on both the Beck Depressions Inventory (BDI) and the Beck Anxiety Inventory (BAI); decreases were noted as 22 to 19 for BDI and 26 to 21 for BAI. The denial letter stated "lower levels of care have not been exhausted". The letter responded that the patient has attempted the following conservative treatments: Rest/off work, exercise program, 12 visits of formal physical therapy limited due increasing pain, TENS unit, four sacroiliac caudal epidural steroid injections which provided temporary relief, lumbar medial branch radiofrequency ablation, medication management and 6 individual counseling sessions. One evaluator found that the patient had developed a pain avoidance syndrome, most likely due to psychological factors, which results in her fear of doing movements with her back/hip. He recommended behavioral therapy. Per interpretation of a functional capacity evaluation in August of 2007,

her provider recommended a multidisciplinary pain management program. A review of the records shows the patient appears to show disuse compared to her prior adaptive, functional capabilities. The treatment plan requested includes functional and behavioral goals with a focus "on transfer of learning for activities of daily living", physical improvement and a home exercise plan. The request for a 2 weeks program is in line with guideline recommendations not to proceed for more than 2 weeks without documentation of subjective and objective gains according to the letter.

On February 18, 2008 an adverse determination letter informing of the non-certification of the request for reconsideration was sent to the provider. The request for chronic pain management was denied with rationale that the claimant has had significant lower levels of care, none of which were reported to be effective. The records provided for review did not reflect that negative predictors of success had been addressed. The documentation did not include adequate and thorough evaluation or document that the claimant has a motivation to change or is willing to forego secondary gain. Two attempts were made to speak with the provider and call back information was left.

On March 10, 2008 a request was made for an IRO.

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

According to the Official Disability Guidelines, 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. 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).

The patient has been provided with extensive conservative care and diagnostic testing, much of which has resulted in contrary results. There is radiculopathy per EMG which has not been corroborated by clinical examination findings. The patient reports benefit from injections and later no benefit from injections. In addition, the patient was not a surgical candidate. Per the functional capacity evaluation, the patient would frequently lie down on the exam table for pain relief. Per a second opinion evaluation, symptom magnification was opined based on a discrepancy of straight leg raising in the sitting and lying position and voluntary restricted range of motion with reference to the hip examination. In this reviewer's opinion, the patient has certainly exhausted lower level care. Additional inconsistencies are noted as follows: The patient states she sees no future yet is looking forward to taking computer classes. The patient's family situation remains intact. The medical records fail to document a significant loss of ability to function independently resulting from the chronic pain, which is a criterion listed by the ODG. Per IME opinions, the patient has minor low back residuals only from her injury. While the patient might benefit from a few sessions of behavioral therapy as recommended to help her learn to live with her residual level of disability, which according to reports, is quite minimal. She does not need additional physical modalities/procedures such as physical therapy, pain management, stress management, psychoeducational group, group psychotherapy, biofeedback, and occupational/vocational counseling. The medical records fail to substantiate a medical necessity for a multi-faceted pain management program. As per prior review opinion, the critical component of the proposed treatment is really the psychological component, and psychological intervention alone may be sufficient to get the patient so that she can return to work. Therefore, my determination is to agree with the previous non-certification of the request for 10 daily sessions of Chronic Pain Management to be rendered at 8 hours per session.

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

The Official Disability Guidelines 03-19-08: Chronic pain management programs are 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) (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) 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.