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Notice of Independent Review Decision

DATE OF REVIEW: April 14, 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

Chronic pain management - 20 sessions

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 December 12, 2007 Progress Report Dr.
- o December 17, 2007 Medical Report, Dr.
- o January 15, 2008 Mental Health Evaluation, M.Ed. LPC
- o February 5, 2008 Preauthorization request for chronic pain management - 20 sessions
- o February 5, 2008 Progress Report, Dr.
- o February 12, 2008 Denial of request for chronic pain management - 20 sessions
- o February 18, 2008 Request for reconsideration, Dr.
- o February 26, 2008 Denial of request for reconsideration
- o March 3, 2008 Subsequent Medical report, Dr.
- o April 3, 2008 request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a xx-year-old employee who sustained an industrial injury to the neck, right hand and right shoulder on xx/xx/xx when he tripped and fell. He is status post right rotator cuff repair times 2 on November 12, 2002 and July 27, 2007, status post right endoscopic carpal tunnel release on September 25, 2003, and status post anterior cervical discectomy, decompression and fusion on May 27, 2004. The patient has been provided with conservative treatments including physical therapy, medications, a brief course of individual psychotherapy and a partial chronic pain management program prior to his last surgery.

Daily Progress Notes of December 7, 2007 state that the patient has shown improved ability for supine punches exercises with less discomfort. The therapy notes indicate both active and passive therapy is being provided.

A progress report of December 12, 2007 notes that the patient can no longer do exercises because his right shoulder pain is too severe. The shoulder demonstrates weakness in all planes. The patient will be referred to his provider for reevaluation of the

exacerbation.

A subsequent Medical report was submitted on December 17, 2007. The patient reports pain that travels from his shoulder to his right thumb when he raises his arm. The patient reports pain with all attempts of range of motion. However, he has nonspecific tenderness of the shoulder girdle. He has no specific tenderness over the rotator cuff. There is no tenderness over the supraspinatus muscle. He has no instability in any plane. There is no crepitation on ranging the glenohumeral joint. He has a negative drooping test. He has a negative lift-off test. He has a negative belly press test and a negative bear hug test. He desires an MRI. Recommendation is to continue physical therapy and probably be advanced to a chronic pain management program.

A Mental Health Evaluation was provided on January 15, 2008. The patient reports that he can not perform daily chores and his wife must help him with bathing and dressing. He reports sad mood, high stress level, pessimism, past failure, self-dislike, indecisiveness, disturbed sleep, increased appetite, inability to relax, fear and nervousness. The rest of the report contains primarily rationale for the patient to enter the evaluator's pain management program.

Request for chronic pain management 5x/week for 4 weeks was not certified in review on February 12, 2008 with rationale that there are too many predictors of failure for a chronic pain management program, particularly significant is the time passed since the injury of 2002, high continuing pain levels despite all treatment attempts, and severe anxiety and depression scores despite medication and individual therapy sessions. The patient has 8 of the 9 predictors of failure.

Request for reconsideration for a chronic pain management program was non-certified on February 26, 2008 with rationale that the request exceeds guidelines for prospective review as there are no other compelling clinical indicators to support re-entry into a tertiary program at this time.

A medical report was submitted in response to the denial for reconsideration on March 3, 2008. The patient was reevaluated on that date for continuing neck and right shoulder pain. The patient states he cannot lift objects with the right hand because of the shoulder pain. The right shoulder wound is well healed. He reports pain in the lateral deltoid area but there is no anterior cuff tenderness. He reports pain with all shoulder motions. He demonstrates 100/180 degrees of flexion, 50/50 degrees of extension, 100/180 degrees of abduction, 46/50 degrees of adduction and 50/80 degrees of internal and external motion. Cervical range of motion is slightly restricted. There is a positive Spurling's test on the right. He demonstrates hypoesthesia to pinprick in the right C7 distribution. The patient has a cervical disc condition, prior right shoulder rotator cuff repair times two, and his symptoms remain unchanged. Recommendation is for a multidisciplinary pain management program.

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

The Official Disability Guidelines, Chronic Pain Programs state, 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. 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. 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.

ODG criteria for the general use of multidisciplinary pain management programs is as follows:

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.

The medical records document that the patient has not improved his condition despite time, physical therapy, medications, independent therapy and brief pain management. 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. The patient has had two prior rotator cuff interventions which complicates his current condition and places him at higher risk for any additional procedures. The medical records fail to document a significant loss of ability to function independently from the chronic pain. The patient states he cannot lift anything with his right hand on March 3, 2008 due shoulder pain. This is essentially a subjective finding lacking corroborative objective clinical examination findings such as testing of upper extremity motor function. The medical records fail to document the current functional capacity of the patient. There does not appear to be a return to work plan of any level of capability or a plan to retrain. The medical records fail to provide the results of imaging of the right shoulder that might clarify his pain generator.

Physical examination findings of a positive Spurling's test on the right and hypoesthesia to pinprick in the right C7 distribution indicate a likely cervical radicular syndrome and other treatments may clearly be warranted. Guidelines state the patient should not be a candidate where surgery or other treatments would clearly be warranted. Guidelines also state the patient should exhibit a motivation to change. As noted above, the patient opted out of physical therapy due shoulder pain, but when examined 5 days later on December 17, 2007, the objective examination findings were unremarkable.

In addition to the predictors of failure factors, the duration of time since the injury, and the apparent need for other treatments, the patient exhibits a negative outlook about future employment and high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability). As the mental health evaluator noted, the patient's response to the injury may presently interfere with his ability to benefit from treatment and may limit his ability to return to work. That is, in fact, the rationale for prior non-certification of a chronic pain management program. The medical records fail to substantiate the optimistic notion that the patient will benefit from such a program and come out of the program able to cope with his residual pain and be able to return to work. In addition, the medical records fail to document a thorough assessment including baseline functional testing so follow-up with the same test can note functional improvement as required by guidelines. The present reviewer is in agreement with prior opinions that the patient has too many predictors of failure to be a good candidate for a chronic pain management program. Therefore, my determination is to uphold the previous non-certification of the request for chronic pain management - 20 sessions.

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
- 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 - 4/11/2008: Chronic Pain Management 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)

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