

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision -- Amended

DATE OF REVIEW: FEBRUARY 19, 2008

AMENDED FEBRUARY 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Chronic Pain Management program times twenty days (five days a week for four weeks).

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter, Dr. 01/16/08

Adverse Determination Letter, Dr. 01/25/08

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Pain – Chronic pain programs)

Letter of medical necessity, Dr., 01/24/08

ER records, 03/08/06

X-rays right shoulder, 03/08/06

Physician records, Dr. 03/13/06, 03/20/06, 03/24/06, 03/31/06, 04/07/06, 04/25/06

MRI right shoulder, 03/28/06
Operative Report, 05/10/06
Office notes, 05/16/06, 06/06/06, 07/06/06, 08/03/06, 09/28/06
Office notes, Dr. 12/14/06, 02/22/07
Behavioral Medicine Testing Results, 12/29/06
Enhanced MRI right shoulder, 01/22/07
Office note, Dr. 04/09/07
X-rays right shoulder, 04/09/07
Office notes, Dr. 04/24/07, 05/29/07, 07/10/07, 08/14/07, 09/11/07
Office notes, Dr. 05/09/07, 06/15/07
X-rays chest, 05/23/07
Behavioral Medicine Re-evaluation, 07/06/07
Addendum, 07/06/07
Physical therapy prescription, 07/10/07
Note, Dr. 07/11/07
MRI lumbar spine, 08/24/07
History and Physical, Dr. 12/003/07
FCE, 01/10/08
Summary of FCE, 01/10/08
Requests for chronic pain management program, 01/10/08, 01/21/08
Information about chronic pain management program
Note, Dr. 01/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a contusion to the right shoulder, fractures of the third and fourth ribs and multiple abrasions after a tractor knocked him over. He was found to have a full thickness rotator cuff tear in the supraspinatus region with significant retraction. On 05/10/06 he underwent arthroscopy of the right shoulder with arthroscopic subacromial decompression, arthroscopic distal clavicle excision and mini open rotator cuff repair. He treated with therapy and activity modification. Prior to 09/28/06 he was declared to be at Maximum Medical Improvement and assigned a 10 percent impairment rating, which was disagreed with by the treating physician.

The claimant had ongoing right shoulder pain and weakness and was diagnosed with a recurrent rotator cuff tear and glenohumeral joint arthrosis. He also had issues with coping and depressive symptoms. On 05/24/07 the claimant underwent arthroscopic revision rotator cuff repair, revision subacromial decompression and partial distal claviclectomy, revision biceps tenodesis and hemocyte autograft placement and suprascapular nerve block. He developed a postoperative infection and in 06/07 underwent right shoulder arthroscopic incision and drainage. Dr. on 07/10/07 recommended therapy, continuation of antibiotics and discussed the likelihood that the claimant would require hemiarthroplasty/total shoulder replacement in the future if his condition did not improve. He was to be off work and it was felt he would have a permanent disability relative to the shoulder.

A lumbar MRI was obtained on 08/24/07 showing generalized posterior protrusions at T11-L2, L1-2, L2-3, L3-4, and L4-5; annular tears at T11-12 and L3-4; varying degrees of canal and foraminal encroachment at these levels, most pronounced canal narrowing at L3-4; a left sided disc protrusion at L5-S1 and a right lateral disc protrusion of L4-5. He was noted to have a lumbar compression fracture.

At the 09/11/07 visit the claimant reported no shoulder pain, but significant limitation of motion and strength. Motion was 140 degrees in abduction and flexion. Continued therapy and off work were advised. Dr. evaluated the claimant on 12/03/07 reporting intractable shoulder pain. The examination noted decreased range of motion of the shoulder, adhesive capsulitis, muscle atrophy of the left shoulder, paravertebral spasm and tenderness in the lumbar spine, decreased lumbar motion, lumbar myospasms and myositis, a positive straight leg raise bilaterally and numbness/tingling with dysesthesias with absent reflexes bilaterally. Lumbar displaced disc at multiple levels, an L2 vertebral compression fracture, right sided L4/5 disc herniation, left sided L5/S1 disc herniation, bilateral lumbar radiculopathy, right shoulder muscle atrophy and disuse, adhesive capsulitis and intractable pain were diagnosed. A chronic pain management program, off work for 30 days, psychiatric and neurosurgical evaluations as soon as possible, continuation of Tramadol and Restoril, Vicodin ES, anti-inflammatory medications, and EMG/NCVs of the bilateral lower extremities were recommended.

A Functional Capacity Evaluation was completed on 01/10/08 noting absent sensation at C7, 1 plus upper extremity reflexes except for the biceps reflex on the right which was 0. There was decreased strength, except in extension, internal rotation and horizontal adduction. The test was valid with a fair effort. It was determined that the claimant was capable of working in a light to medium level capacity and may benefit from a chronic pain program. The requested chronic pain management program was denied on two reviews dated 01/16/08 and 01/25/08 and is currently under dispute.

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

I was asked to review the information and determine if a chronic pain management program was indicated. This was reviewed on two occasions and denied. This is a very complex case. This gentleman has had continued complaints of right shoulder pain. He underwent two orthopedic surgical procedures regarding his shoulder. He initially underwent a rotator cuff repair. It failed. An attempted revision was performed. However, following such, he developed an infection and has been left with ongoing complaints of pain. He was treated with what appeared to be physical therapy. He also has back pain. Dr. felt that he was unable to work and had permanent disability with respect to his shoulder.

It appears that the claimant has had extensive treatment and has not reached baseline function. He has had an adequate and thorough evaluation. It appears that therapy has not been beneficial and it is unlikely that further surgery will help. Based on the information, it appears that he has not regained full shoulder motion and has residual weakness with concomitant chronic pain. I do not feel that any further surgical measures would be helpful. I could not assess his motivation to change or if there is any secondary gain. There were no negative predictors of success. Due to his ongoing complaints of pain and failure to respond to treatment including medication and therapy, I see no reason why a chronic pain program would not be in order. He has failed conservative treatment of an extensive nature and appears to have a non-operable condition which has plateaued and results in ongoing pain and limited function. Based on my review of the information for the above mentioned reasons, I feel that a chronic pain management program for 20 days, 5 days a week for 4 weeks, would be appropriate as a final measure to help his ongoing complaints of pain.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Pain – 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) 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.

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
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)