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Notice of Independent Review Decision

DATE OF REVIEW: February 11, 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

Multidisciplinary chronic pain management program five times per week for two weeks

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 17, 2007 utilization review report
- o January 10, 2008 utilization review report
- o January 4, 2008 utilization review report
- o December 29, 2007 pre-authorization request from Clinic
- o December 28, 2007 response to denial letter from M.S., L.P.C.
- o December 12, 2007 chronic pain management program treatment goals and objectives from Health Associates
- o July 16, 2007 functional abilities and evaluation by D.C.
- o November 18, 2005 electrodiagnostic report by M.D.
- o October 31, 2005 lumbar spine MRI report by M.D.
- o December 12, 2007 progress report by M.S.
- o July 16, 2007 functional abilities evaluation by D.C.
- o October 18, 2007 progress note from FNP

Patient Clinical History [Summary]:

According to the medical records, the patient sustained an industrial injury. A non-certification was rendered for the above-captioned request on December 17, 2007. The peer review report states that the patient has been diagnosed with depression and lumbago. It notes that the patient complained of decreasing sleep, decreasing physical function, constant back pain, increased depression/anxiety, a Beck Depression Inventory score of 21 and a Beck Anxiety Inventory score of 18. The reviewer was reportedly not given the results of x-rays, electrodiagnostic studies, and MRI. The report notes that the claimant had undergone a short period of individual psychotherapy with some improvement. The depression inventory score had

decreased from 26 to 21 and the anxiety score from 26 to 18. The pain level was 8/10 and had been reduced to 7/10. However, his psychosocial stressors went up from 3 to 4. The reviewer stated that the claimant has significant psychosocial stressors that predict failure in the requested program. It was also noted that a reason for denial was that the reviewer was not provided with the diagnostic tests to date that would be helpful in this determination.

A December 28, 2007 response to denial letter was submitted for review. The letter states that regarding the reason for denial of significant psychosocial stressors that predict failure, it should be noted that throughout his individual counseling the patient did make improvements despite experiencing psychosocial stressors. The treatment progress report documents that the patient's affective symptoms have decreased, as well as a sleep disturbance slightly improving. The letter states that there are several healthcare providers recommending a multidisciplinary treatment approach for the patient. A physician has recommended participation in a chronic pain management program to assist him and successfully transition him back into the workforce, decreasing his affective symptoms, improving sleep, and increase in his level of physical functioning. On July 16, 2007, another doctor commented after completing a functional capacity evaluation that the patient remains very pain focused and he is concerned about inability to return to his job as a mover. The patient stated that his latest round of injections were denied and he was told that he is not a surgical candidate until such time that he can no longer deal with the pain. The patient has stated that he really does not want to undergo surgery. The letter quotes the Official Disability Guidelines, stating that variables have been found to be negative predictors of efficacy of treatment with chronic pain programs. The letter notes that the patient has not been these indicators and is clearly an excellent candidate given his preinjury work adjustment in his improvement in decreasing affective symptoms, and decreasing the psychosocial stressors. The letter states that the patient meets all the criteria specified by the ODG for use of a multidisciplinary pain management program.

On January 4, 2008, the case was reviewed again and another non-certification rendered. The report states that this injured worker sustained an injury. In conversation with one of the providers, the reviewer was informed that the patient did have significant stressors, but he had progress with the six individual psychological sessions provided. The reviewer stated that there are too many predictors of failure including (1) a negative outlook about future employment (2) high levels of psychosocial distress (higher pretreatment levels of depression, pain, and disability) (3) duration of pre-referral disability time (4) prevalence of opioid use, and (5) pre-treatment levels of pain. The reviewer noted that the patient has become treatment dependent and this program would feed his dependency for ongoing treatment.

A peer review report, dated January 10, 2008, states that the patient's current medications are Norco, Mobic, Lexapro, and Skelaxin. This report notes that the patient has had previous treatment that has included 20 sessions of the chronic pain management program in January 2007. The reason for non-certification was that the patient had completed this program in 2007 and there are no evidence based outcome studies that suggest repetition of a tertiary level program is potentially effective after one has been completed and failed. The reviewer stated that he spoke with one of the providers who was unaware that he has completed a previous program.

An October 31, 2005 lumbar spine MRI report has been submitted for review. The report documents a broad-based central and right paramedian disc herniation at L5-S1 effacing the ventral aspect of the thecal sac, but without neural element compression. There was possible effacement of the right lateral aspect of the thecal sac at the L5-S1 disc level by prominent right lateral epidural fat. There was in appearance at L5-S1 accentuated by the conjoined root sleeve of the right involving the S1 and S2 roots. Schmorl's nodes were noted at the anterior aspect of the inferior L3 and L4 endplates.

An electrodiagnostic study was completed in November 2005 with an impression of a lumbar radiculopathy that affects the right L5 and S1 nerve roots. The root compromise exhibited both acute and chronic characteristics with denervate and re-innervating potentials. There was electrodiagnostic evidence of a significant demyelinating peripheral neuropathy that affected both motor and sensory fibers.

Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision:

According to the Official Disability Guidelines, treatment with a chronic pain management program 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. According to the medical records, the patient has undergone such a program in January 2007 that consisted of 20 sessions. He failed that program. This program would constitute the two weeks of a trial recommended for appropriate candidates by the Official Disability Guidelines and meets the maximum number of visits suggested by the guidelines. Given that the patient has not demonstrated efficacy over the course of the first two weeks of that program or after the 20 sessions, a repeat program would not be indicated. Therefore, my determination is to uphold the previous decision to non-certify the request for a multidisciplinary chronic pain management program five times per week for two weeks.

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 KNOWLEDGBASE

____ 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:

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) (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.