

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/02/2008

**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 Additional days of Chronic 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 December 29, 2006 Behavioral Medicine Testing results from Treatment Center
- o December 3, 2007 History and Physical for CPM from Dr.
- o July 6, 2007 Behavioral Medicine Re-evaluation from Treatment Center
- o April 9, 2008 Functional Capacity Evaluation from, PT, Treatment Center
- o April 11, 2008 Medical report from, MS, LPC, CRC, Treatment Center
- o April 11, 2008 request for Preauthorization from Dr.
- o April 16, 2008 Preauthorization Review Summary of denial, Dr.
- o April 22, 2008 Request for reconsideration/Appeal from, MS, LPC, CRC
- o April 23, 2008 Request for reconsideration for 10 additional days of a CPMP
- o April 28, 2008 Preauthorization review Summary of denial for reconsideration
- o April 28, 2008 Preauthorization review Summary denial for reconsideration
- o May 19, 2008 Request for IRO

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records available for review, the patient is a xx-year-old employee who sustained an industrial injury to the right shoulder on xx/xx/xx when he fell while working on a tractor tire that began to roll. Emergency room treatment was provided and fractured ribs were identified on x-rays. An MRI of March 28, 2006 showed a rotator cuff tear which was subsequently repaired via arthroscopic mini-open repair on May 10, 2006 followed by 12 sessions of physical therapy. He has been under the care of his current provider since October of 2006. The patient's medical history includes hypertension, diabetes and heart disease. He is described as 6 feet tall and 230 pounds and smokes 1-2 packs of cigarettes daily.

Since transferring care to his current provider the patient has been provided a surgical consultation in April of 2007, x-rays in May and June of 2007, passive and active treatments, physical therapy, a second surgery on May 24, 2007 and a third surgery on June 26, 2007 secondary to infection. On March 3, 2008 the patient began a 20 day interdisciplinary pain rehabilitation program (IPRP) to facilitate return to work and case closure.

Per a function capacity evaluation of April 9, 2008 (Interim PPE) the patient has a diagnosis of failed right rotator cuff tear with post-op infection; progressive adhesive capsulitis right shoulder; intractable pain, sleep disturbance; anxiety and depression secondary to his industrial injury and right shoulder muscle atrophy secondary to disuse. The patient is reported to be able to

function at the Medium Physical Demand Level based on a static arm test. It is noted that the patient is unable to squat due right knee pain and continues with low back pain and right radiculopathy. The reported factors/percentages of improvements are compared with a previous test which was performed over 60 days prior to entering the IPRP on December 27, 2007.

On April 11, 2008 request was made for an additional 10 days of IPRP with rationale that the patient had completed 18 days with good response. The patient was able to reduce his pain level and reported a reduction in muscle stress. Prior to entering the IPRP program, the patient could not sit for more than 45 minutes. Currently he can sit for 1 hour. Before entering the program, the patient could tolerate driving for only 1 hour. Currently, he can tolerate driving for 2 hours. An additional 10 days of IPRP was requested to stabilize active symptoms on a long-term basis, increase his functional tolerances, and maintain a safe return to work. After 18 sessions of IPRP the patient is reported to have a significantly dysfunctional right shoulder with no rotator cuff function. The patient plans to return to his previous employment which requires a Very Heavy PDL. If he cannot reach a very heavy PDL, he has expressed interest in self-employment with small engines.

Request for an additional 10 days of IPRP was not certified in review on April 16, 2008 with rationale that the patient was not going back to his heavy PDL job but was planning self-employment fixing small engines. The patient has had 160 hours of pain management program which is sufficient exposure to physical and psychological self-regulation scales to transition to self-employment.

On April 22, 2008 request was made for reconsideration of an additional 10 days of participation in an IPRP. It was noted that the goal of IPRP is to return the patient to his prior employment. The last 10 days of IPRP would allow him to return to his former employer with minimal restrictions. His interest in self-employment does not mean he is not a candidate for additional IPRP. The patient has not yet reached a plateau. The patient's use of Darvocet has decreased from 3-4 times daily to 1-2 times daily. A physical therapy evaluation of March 26, 2008 is submitted to document progress in the IPRP.

Request for reconsideration was not certified in review on April 28, 2008 with rationale that, the medical records failed to include a specific diagnosis. The FCE failed to document that rapid exchange grip with calculation of coefficient of variation was included in the evaluation which raises the question of the validity of the FCE. The report of 4-22-08 failed to document objective clinical parameters that would substantiate report that the patient continues to progress and benefit "physically/functionally" from the IPRP. The items of progress in the report are subjective. It was noted that the patient can now sit 1 hour but also can drive for 2 hours which is inconsistent. The report of decreased medication use was not clear in regard to how many tablets the patients takes each usage. It was also noted that the patient has had 3 surgical interventions to his shoulder which indicates he may have a rotator cuff tear that has broken loose and is surgically repairable without need, therefore, of IPRP.

On May 19, 2008 request was made for an IRO.

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

The medical records document a xx-year-old overweight patient with a history positive for hypertension, diabetes and heart disease who continues to smoke 1-2 packs a day. He is also unable to squat due right knee pain and continues with low back pain and right radiculopathy. He has been provided 20 sessions of interdisciplinary chronic pain management for a failed rotator cuff repair times 3 and the clinician argues that with 10 more sessions the patient will have a good chance to return to his prior employment with minimal restrictions. The patient, who appears to know better, is also considering self-employment.

The literature has marked hesitancy in recommending multidisciplinary chronic pain programs: 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. In this case, the patient appears to have primarily physical limitations in his shoulder with a diagnosis, per a FCE report of, failed right rotator cuff tear with post-op infection; progressive adhesive capsulitis right shoulder; intractable pain, sleep disturbance; anxiety and depression secondary to his industrial injury and right shoulder muscle atrophy secondary to disuse.

I am in agreement with the prior review that the progress items of the April 11 report are subjective. It is also noted that the progress/improvement factors of the PPE report are based on comparison with a prior evaluation of December 27, 2007, over 60 days prior to the patient entering the IPRP. The medical records fail to provide a clear picture of the patient's condition based on objective clinical examination findings. Most important, as noted prior, it does appear that the patient has a failed rotator cuff repair as intractable pain continues after 3 surgical interventions. According to ODG criteria, the patient is not a candidate where surgery or other treatments would clearly be warranted. Per the report of April 11, the patient has a significantly dysfunctional right shoulder with no rotator cuff function. There is strong indication that an additional surgery will be needed. The patient is at a Medium PDL and 10 additional days of IPRP are not likely to bring him to Very Heavy PDL as required by his former job. Overall, the medical records fail to substantiate that additional participation in an IRPT will improve his long-term outlook. Therefore, my

determination is to agree with the previous non-certification of the request for 10 additional days of Chronic 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
- 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 Chronic Pain Management Programs - 5-19-08:

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 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. 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.

Functional Restoration Programs:

Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs.

Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006)

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) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see Chronic pain programs.