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Notice of Independent Review Decision

DATE OF REVIEW: May 12, 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 program, eight hours/day, five times four

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 19, 2006 report by M.D.
- o April 24, 2007 designated doctor evaluation report by M.D.
- o May 3, 2007 designated doctor evaluation report by M.D.
- o January 20, 2005 initial evaluation report by D.O.
- o July 24, 2007 lumbar myelogram report by M.D.
- o April 24, 2007 electrodiagnostic study report by M.D.
- o May 9, 2007 report by M.D.
- o December 7, 2007 letter of clarification by M.D.
- o December 17, 2007 letter of clarification by M.D.
- o September 6, 2007 reported medical evaluation report by M.D.
- o November 3, 2005 through March 28, 2006 work status reports and medical records from D.O.
- o December 20, 2006 through January 3, 2008 work status reports and chart notes by D.C.
- o February 8, 2007 work status report by D.C.
- o December 20, 2006 and December 21, 2006 functional capacity evaluation report/physical performance evaluation report from Diagnostics
- o December 20, 2006 Physical Performance Center fee sheet
- o November 14, 2005 Memorial Hospital records
- o November 14, 2005 x-ray report by M.D.
- o Copies of guidelines from the ODG, ACOEM, and other sources
- o January 21, 2008 physical performance exam report from Chronic Pain Management
- o February 14, 2008 through March 28, 2008 reports by M.Ed., LPC and Health Care Systems

- o February 5, 2008 initial consultation report by M.D.
- o employer's first report of injury or illness
- o December 15, 2005 notice of denial
- o April 28, 2008 independent review Organization summary
- o March 14, 2008 utilization review report
- o April 8, 2008 utilization review report

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury involving the lower back due to lifting. On May 3, 2007 she was provided a 15% whole person impairment rating by a designated doctor after a lumbar spine MRI had been non-certified by the insurance carrier. On January 20, 2008, the patient was evaluated by the same designated doctor. The report states that the patient reported no changes since the last visit and that her lumbar spine is still being denied. She had a contested case on November 14, 2007 and her cervical spondylosis and cervical degenerative disc disease are now compensable. She complained of eight out of 10 neck, upper back, and lower back pain. She stated that she is taking Tylenol #3, Flexeril, and Robaxin. The patient was examined and provided a diagnosis of cervical strain and failed lumbar fusion.

A physical performance examination was performed on January 21, 2008. The report states that the patient has only had physician management with no passive or active therapy. She was taking Flexeril and hydrocodone for the pain. The report states that the patient's physical demand level for her job is medium. She tested at a sedentary-light physical demand level. However, it should be noted that the report states that she was very cooperative during the evaluation, but it was felt that she gave less than a genuine effort. She was, however, deemed a great candidate for a chronic pain management program.

She was evaluated by a pain management physician on February 5, 2008. The report states the patient is a female with chief complaints of pain in the neck, low back, and right leg. It states that the patient does not smoke, drink alcohol, or use drugs. The physician stated that he believes that a chronic pain program that is comprehensive in nature would be beneficial for the patient. Modalities such as rehabilitation, physical therapy, psychological counseling, and biofeedback can help the patient deal with the pain and improve coping strategies.

She underwent a chronic pain management evaluation on February 15, 2008. The report states that she initially injured herself while lifting boxes of quarters to place in a safe but she immediately felt pain in her lower back. She continued to experience constant low back pain with radiating symptoms down the bilateral extremities with tingling and numbness noted. At the time of the evaluation, she was not working but would like to return to work. She reported that none of the treatment has been helpful thus far. Medications included Flexeril, Tylenol, and hydrocodone with dosages unknown. Restrictions include walking, lying, standing, bending, twisting, driving, and performing household chores. She notes that the pain is influenced by stress and tension. Injury related lifestyle changes include an inability to work, physical restrictions, and increased marital stress. She reports being withdrawn since the injury with decreased libido. She denies a history of psychological disorders. She stated that she gets four to five hours of fragmented sleep per night with fair quality. She reports moderate fatigue 50% of the time.

She was administered the Beck Anxiety Inventory and scored a five which indicates minimal anxiety. She was also given a Beck Depression Inventory with a score of four which indicates minimal depression. The Fear Avoidance Beliefs Questionnaire indicated high fear avoidance tendencies for work-related tasks. Problems identified included chronic pain syndrome, possible overuse of pain medications, and inability to return to work due to the above problems. The report states that she would benefit from chronic behavioral pain management program as pain continues to interfere with her life and she is at risk for developing an excessively disabled lifestyle. She has a notable reduction in her ability to engage in normal social and recreational activities. Her personal relationships are influenced by pain. Surgical intervention has been discussed but not approved by the carrier according to the report. She reportedly is expected to have a good response to treatment, a good prognosis for returning to work, and a good prognosis from benefiting.

On March 14, 2008, a non-certification was rendered for a request for 20 days of a chronic pain management program consisting of eight hours per day. The report states that the BDI and BAI are within normal limits. The patient does not meet the criteria for psychological component of chronic pain management according to the reviewer. There was an inadequate interval history. The Official Disability Guidelines pain chapter was referenced.

The records include a March 28, 2008 appeal letter. The letter states that a chronic behavioral pain management program that provides a psychological component is not recommended due to significant depression and anxiety, but due to high fear avoidance tendencies. The psychological portion of the program will focus on educating her on non-medicinal pain management techniques, biofeedback training, deep breathing, cognitive behavioral techniques to reduce fear avoidance tendencies, and several other measures.

On April 8, 2008, the request for chronic pain management was again reviewed and a non-certification rendered. This report states that the patient is status post fusion and suffering from chronic low back pain and failed back syndrome. The spinal fusion was performed in 1986 with hardware removal in 2000. However, the reviewer stated that the intake physical performance exam from January 21, 2008 past medical history section is listed as "insignificant." It also states that there was documentation of 0 pounds ability to lift on both the NIOSH lifts testing and dynamic lift assessments. No physiological parameters were documented as being measured. There were no validity checks performed.

January 20, 2005 electrodiagnostic study involving the upper extremities was found to be normal. She underwent a July 24, 2007 lumbar myelogram with conclusions of L2-3 minor retrolisthesis, mild to moderate facet arthrosis at L2-3 and L3-4, some question about the adequacy of the fusion at L4-5, and solid anterior and posterior fusion at L5-S1. X-rays of the lumbar spine on that date revealed a retrolisthesis of L2 on L3 with the patient in the prone position which remained relatively unchanged in

extension and flexion. On April 24, 2007, she underwent an electrodiagnostic study of the lower extremities with an impression suggestive of proximal neuropathy versus lumbar radiculopathy and evidence of bilateral saphenous neuropathy.

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

The medical records reflect that the patient underwent a physical performance examination on January 21, 2008 and it was felt by the examiner that she gave less than a genuine effort. The criteria for admission to chronic pain management specified by the Official Disability Guidelines include baseline functional testing so follow-up with the same test can note functional improvement. Without physical testing that was performed in a manner with genuine effort, subsequent testing cannot be adequately compared to the initial testing. Therefore, this renders the initial testing not useful. In addition, the guidelines state that treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The total treatment duration should generally not exceed 20 sessions according to the guidelines. This request is for 20 sessions of chronic pain management, which is not an appropriate initial trial. Given these circumstances, I agree with the previous non-certifications and determine that these should be upheld.

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

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) (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.