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Notice of Independent Review Decision

DATE OF REVIEW: 05/27/2008

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

An additional 10 sessions (days) of a 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 March 10, 2008 Physical Performance Evaluation from Dr.
- o April 1, 2008 CPM program treatment progress report from, MS/LPC
- o April 9, 2008 Request for pre-authorization, multidisciplinary outpatient CPM program
- o April 11, 2008 Review for CPM with rationale for denial from Dr.
- o April 14, 2008 Letter of Non-certification for request of an additional 10 days of CPM
- o April 29, 2008 Request for appeal for outpatient CPM program from, MS/LPC
- o April 28, 2008 Response to denial letter from, MS/LPC
- o May 1, 2008 Review for reconsideration for CPM with rationale for denial from Dr.
- o May 1, 2008 Letter of denial for request for reconsideration, additional 10 days of CPM
- o May 15, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a xx-year-old who sustained an industrial injury to the pelvic and thigh regions with a resulting psych component when she fell 8 feet when cleaning a machine on xx/xx/xx. The patient is status post open reduction and internal fixation of a comminuted fracture of the distal left femur on xx/xx/xx which was followed by physical therapy. Good alignment and healing were realized and the hardware was removed on June 1, 2006.

On March 10, 2008 the patient underwent a Physical Performance Evaluation. She reported constant left knee pain with numbness and tingling rated as 6/10. Rest and medication provide relief. On examination, the patient reports decrease in sensation and tingling along the surgical area. The patient ambulates slowly with aid of a cane. On examination, there is tenderness with palpation at the left knee. Medial/lateral stress test is positive. Left knee flexion is 117/150, left lower extremity motor strength is 4/5 at the hip, knee and ankle muscle groups. Right grip strength is mildly decreased. Recommendation was

for the patient to continue the chronic pain management program (CPMP) for the functional deficits noted. The patient shows chronic pain behavior such as frequent verbalizations of pain with general mobility. He reports feeling of depression and frustration about his injury.

A chronic pain management treatment progress report was submitted on April 1, 2008 following 20 days of pain management. The patient was noted to be using medication of Ultram at 100 mg daily and Celebrex of 200 mg daily which was 50% less than the daily dosage for each medication prior to initiation of pain management. The program has components of physical rehabilitation and psychological/behavioral health.

The program includes four daily group sessions with topics such as pain management, stress management, learning to relax and worry less. The patient was noted to have realized improvements in the pain disorder component of her diagnosis from 20 days of CPMP as demonstrated by improved scores in tests such as the Revised Oswestry Low Back Pain Disability Questionnaire (54% to 45%), Pain Experience Scale (83.5 to 35), McGill Pain Questionnaire (40 to 30), Fear Avoidance Beliefs Questionnaire, physical sub scale/work sub scale (13 & 27 to 17 & 37) and he patient's report of pain level was reduced from 5/10 to 3-4/10. Additionally, the depressive disorder component of the patient's diagnosis was improved as evidenced by testing such as Beck Depression Inventory score reduced from 17 to 10, Beck Anxiety Index score reduced from 8 to 4 and Sleep Questionnaire score reduced from 31 to 18. Based on these improvements, request is made for an additional 10 days of CPMP.

Request for continuation of the chronic pain management program was not certified in review on April 11, 2008 with rationale that the request for an additional 10 days of CPMP is not medically necessary. The claimant has completed 20 sessions of CPMP and there is no clear rationale to go beyond the recommended visits based on The Official Disability Guidelines.

The provider responded with an appeal letter dated April 28, 2008. The patient's progress has been documented. However, per the Revised Oswestry Index, the patient continues with a severe level of disability. In addition, her scores on the Fear Avoidance Beliefs Questionnaire continue to be in a significant range. It is therefore medically necessary for her to continue to participate in the CPMP to progress further and fully overcome symptomatology and resolve associated psychosocial stressors.

The request for reconsideration was not certified in review on May 1, 2008 with rationale that the medical necessity was not substantiated. The medical records failed to include follow-up PPE findings beyond the 3-10-08 records submitted by the clinician. The appeal letter opines that continued CPMP participation is necessary in order to fully overcome symptomatology and resolve associated psychological stressors. Many patients can work with some degree of pain, while others appear disabled out of proportion to physical findings. Pain management should focus on coping and adaptation in order to restore function. Pain often decreases as other areas of life are normalized. The desired end point in pain management is return to function rather than complete or immediate cessation of pain. Patients may be reassured that with increasingly normal physical function, pain will become increasingly more manageable as per ACOEM guidelines. Pain, Suffering, and Restoration of Function Chapter 6. p.116. 2003-2006. In addition, per ODG, total treatment duration should generally not exceed 20 days.

On May 15, 2008 request was made for an IRO

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

On examination on March 10, 2008 the patient reported decrease in sensation and tingling along the surgical area. This is a normal residual associated with scar tissue which the patient can be anticipated to live with and will not be improved with physical or psychological therapies. It was also noted that the patient ambulates with a cane and has a positive medial /lateral stress test. It is not clear from the reports of what treatment has been planned for instability in the knee associated with collateral ligament pathology. It is unclear if the patient has some internal derangement of the knee or merely normal post-surgical paresthesias in the scar tissue region of his knee.

The medical necessity for additional CPMP is not supported. Per ODG, total treatment duration for CPMP should generally not exceed 20 days. 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. Prior review rationale that emphasis should be on functional restoration versus cessation of symptomatology is substantiated by chapter 6 of ACOEM. The stated goal of ACOEM is restoration of functional capacity versus focus on symptomatology. In addition, this reviewer also points out the lack of updated PPE findings beyond the 3-10-08 report of the provider. The medical records fail to substantiate the medical necessity for additional 10 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:

X 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

____ 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 - 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.

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)

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.

According to the ACOEM Guidelines, second edition, page 59, restoring prior activity levels is a principal goal of treatment. When and if that goal is reached, the exacerbation will be said to have seized.

The ACOEM guidelines state on page 106 that treating pain, even acute pain, should emphasize functional restoration rather than relief of pain because the latter may reinforce psychological, environmental, and psychosocial factors that predispose progression to chronic pain states. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. Page 115 states that further treatment should be appropriate for the diagnosed condition(s), and should not be performed simply because of continued reports of pain.

The ACOEM Guidelines state on page 114 that the hallmarks of a good therapy program include a thorough, multidisciplinary assessment of the patient; the establishment of a time-limited treatment plan with clear functional goals; frequent assessment of the patient progress toward meeting such goals; and modification of the treatment plan as appropriate, based on the patient's progress.