

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## Notice of Independent Review Decision

**DATE OF REVIEW:** February 19, 2009

**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 (Board Certified) 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, 20 sessions

### **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 August 7, 2008 report from, D.C.
- o June 28, 2007 operative report by M.D.
- o February 10, 2009 pre-authorization reconsideration from, M.D.
- o January 9, 2008 to September 23, 2008 records from, M.D.
- o December 16, 2008 to January 20, 2009 records from
- o May 15, 2008 through May 19, 2008 records from Hospital
- o January 23, 2009 and February 10, 2009 preauthorization review summaries from

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

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. On June 20, 2007, the patient underwent left knee arthroscopy with removal of loose bodies. The patient underwent total knee arthroplasty on May 15, 2008. As of May 27, 2008, it was noted that he was doing pretty well and he was encouraged to continue with range-of-motion exercises. On June 25, 2008, he was advised to continue with a CPM unit as he was still having pain at 90 to 95 degrees of flexion.

A July 8, 2008 note states that the patient developed some drainage of the wound a few weeks previous and has a little ulcer in the left groin. There are no fevers and no effusion in the knee. There are no temperature changes. An x-ray showed good position of the implants. His range of motion was 5-90 degrees. He was started on physical therapy. On September 23, 2008, it was noted that the patient was in the middle of physical therapy. He had about 10 degrees of lack of extension in the knee and complained of constant pain, although the pain is much better than preoperatively. Preoperatively the pain was 9/10 and it went to 5/10 but it interferes with his activities of daily living. X-ray showed that the implants are in good position. The patient had an extension contracture preoperatively and developed postoperatively from lack of timely aggressive therapy. The physician recommended a pain program.

The patient underwent an evaluation for a chronic pain management program on December 16, 2008. Complaints consisted of

intermittent pain to the left knee rated at a 7/10 to 8/10. He had increased pain when performing daily activities. Objective findings were listed as several psychological symptoms of depression and anxiety. He indicated a decrease in coping skills with managing his pain levels. The impression was listed as follows: Axis I: Adjustment disorder with mixed anxiety and depressed mood; pain disorder associated with psychological factors and the general medical condition, chronic. Axis II: Knee osteoarthritis. Axis III: Deferred. Axis IV: Psychosocial stressors 4 severe; chronic pain, multiple social losses and hardships. Axis V: Current GAF: 65.

His depression inventory score was 21 indicating a moderate range of depression. His anxiety inventory score was 42 which was a severe level of anxiety. A Screener and Opioid Assessment for Patients in Pain was administered and the patient scored a seven which indicates a high risk for abuse of prescribed narcotic pain medication. This is at the low end of the range which identifies 91% of those who actually turned out to be at high risk.

The report states that the patient's complex medical condition has not responded well to treatment. The patient's global functioning score meets the requirement of 40-90 for admission to the program. He exhibits pain behavior, functioning limitations, and mental/emotional dysfunction. Pain has persisted beyond the expected tissue healing time. He continues to express unrealistic expectations regarding outcome of intervention and relief of his own symptomatology.

A request for a chronic pain management program was non-certified on January 23, 2009. The peer review report states that the patient has a two-year history of knee pain complaints and had undergone a left total knee replacement with an unspecified date. Notes from September 23, 2008 indicated that the patient's pain improved by about 50%. The patient was still in the middle of physical therapy but a pain program was recommended. There was no explanation as to why the patient continues with pain complaints despite total knee arthroplasty. A current physical examination was not present.

The request was again reviewed on February 10, 2009 and a non-certification rendered. The report states that the rationale for the pain management program was for the patient to be weaned from narcotic medication and undergo pain management techniques. He was to be referred for re-training. The report notes that the patient is indicated to not be a candidate for return to work as a custodian or other similar work. The peer review physician stated that there was no indication that the patient had been tried on medication weaning by the prescribing doctor. The patient would not be expected to be on narcotic medications for status post total knee replacement. Prior to participation in a pain management program, the ODG would support the patient to be weaned from narcotic medications and then reevaluated for future work options.

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

The records reflect that at the time of the recommendation for a pain management program, the patient demonstrated an extension contracture which apparently worsened postoperatively from a lack of timely aggressive therapy. The patient was continuing physical therapy at this time and had made improvements in subjective pain complaints. As noted below, the ODG guidelines state that a criterion for admission to a pain management program is that there is an absence of other options likely to result in significant clinical improvement. It is conceivable that further physical therapy to address a contracture and pain levels would result in improvement. There is no explanation in the records as to the patient's continued significant pain levels following total knee arthroplasty.

In addition, it is noted that the ODG states that treatment is not suggestive for longer than two weeks without evidence of compliance and significant subjective and objective gains. This request exceeds an initial two week duration. Given these factors, the medical necessity of this request is not substantiated. Therefore, my recommendation is to uphold the previous non-certification.

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

  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 (2009):

Chronic pain programs (functional restoration programs):

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), 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 & occupational 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) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders.

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)

Timing of use: Early intervention is recommend (3 to 6 months post-injury) depending on identification of patients that may benefit from early intervention via a multidisciplinary approach. See Chronic pain programs, early intervention. The probability of returning to work for those out over two years may be less than 1%, if such patients are not offered quality, comprehensive interdisciplinary functional restoration programming. In a high-quality cohort study, the short-term disabled group (4-8 months post-injury) achieved statistically higher RTW compared to the long-term disabled group (> 18 months post-injury), suggesting that early use of a functional restoration program is efficacious, but individuals with long-term disability still achieved respectable RTW justifying use of the program. (Jordan, 1998) (Infante-Rivard, 1996) (TDI, 2007)

See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.

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) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
  - (2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
  - (3) 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;
  - (4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided;
  - (5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;
  - (6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;
  - (7) Negative predictors of success above have been addressed;
  - (8) These programs may be used for both short-term and long-term disabled patients. See above for more information under Timing of use;
  - (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures 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;
  - (10) 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;
  - (11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury.
- 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.