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DATE OF REVIEW: 07/08/2009 Amended 7-13-09

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 Chiropractor, 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 Sessions Work Hardening Program

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

0Upheld (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 02-20-09 Physical Performance Exam from Healthcare Systems (signature illegible)
- o 02-20-09 Psychological Evaluation from MA, LPC
- o 03-16-09 through 03-20-09 Exercise notes - work hardening program (signature illegible)
- o 04-01-09 through 04-13-09 Work Hardening Program progress notes
- o 04-06-09 Work Hardening Program Group Therapy notes
- o 04-15-09 Physical Performance Exam from Healthcare Systems (signature illegible)
- o 04-15-09 Adverse Determination Notice
- o 05-27-09 Adverse Determination after reconsideration letter from
- o 06-12-09 Request for IRO
- o 06-24-09 Signed confirmation page
- o 06-24-09 Company Request for IRO
- o 06-25-09 Notice of Case Assignment

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a employee who sustained an industrial injury to the low back and right lower extremity on xx-xx-xx when she slipped on a ramp while carrying boxes from a freezer. The medical records indicate the patient has participated in treatment including 6 sessions of physical therapy and two epidural injections with short term relief. Lumbar MRI was performed in October 2008 and reportedly showed no acute process from the injury. EMG of November 2008 showed evidence of chronic denervation at the right L3-4. The patient has a history of depression and is overweight. Per a PPE of February 20, 2009 the patient's work requires a medium PDL and she is at medium light. The patient was certified 10 sessions of work hardening in March 2009.

The patient was assessed psychologically for fitness in a work hardening program on February 20, 2009. The patient fell on her

left knee. The patient worked an additional 6-7 months after the injury. She reports right leg, lower back and bilateral shoulder pain as well as feeling of depression. She would like to return to work. She is using Darvocet, Relafin, Baclofen and Lidocaine cream. She rates her pain as 5/10 with medication. The patient has learned how to effectively cope with and tolerate pain. Positive coping strategies include dealing with it until it goes away. She has pre-existing mental health issues and treatment for depression. She has a good support system. She reports sleep difficulty. Testing shows moderate depression and mild anxiety. She has a chronic pain disorder. She has symptoms of depression/anxiety and inability to return to work due to the above

problems. Work hardening is recommended with rationale that, she has a job to return to, she has mild to moderate depression and she wants to get physically improved. The program would include supportive psychotherapy/emphatic listening, CBT, biofeedback, self regulation/relaxation training, promotion of self-efficacy, visualization/guided imagery, coping skills training, pain management training and stress management.

A Physical Performance Examination was conducted on February 20, 2009. The patient's work duties require lifting up to 50 pounds floor to waist level. Her complaints are stated as intermittent low back pain, dull, like a muscle worked too hard. She has had six sessions of PT and two injections. Lumbar flexion is to 43 degrees and extension to 11 degrees. She can lift 36 pounds to her waist (light medium capacity).

The patient initiated work hardening on March 16, 2009. She has a good support group with family and friends. She has a job to return to. She has completed high school as well as 39 credits toward her college degree. The patient states her expectation as, to feel better.

Exercise notes of March 2009 indicate the patient is attending work hardening 6-8 hours daily with resistance exercises as part of the program. On March 30, 2009 she can lift and carry 46 pounds.

Group therapy notes dated March 30, 2009 indicate the patient is going to college and plans to enter the field of criminal justice with her degree.

Work hardening progress notes of April 1, 2009 note the patient has attended 6 of 8 sessions at the end of her third week in work hardening. Several days were missed due to a sick child but she is a lot happier and is laughing in group therapy and is "just shy" of her required PDL. The progress notes indicate she can lift 46 pounds floor to knuckle.

On April 2, 2009 the patient reportedly attended a DDE and was deemed at MMI with note that she is not likely to improve with future active medical treatment. Recommendation was for an FCE.

Group Therapy notes of April 6, 2009 notes the patient is learning how to deal with her pain and to continue with her life. Work hardening progress notes of April 6, 2009 note the patient can carry 46 pounds. Notes of April 13, 2009 indicate the patient has attended 10 of 12 sessions at the end of week five in the work hardening program. Lifting ability remains at 46 pounds. She appears happier and enjoys socializing with the other patients. Her motivation to return to work appears strong.

A Physical Performance Examination of April 15, 2009 state the patient has completed 10 sessions of work hardening. Lumbar flexion is to 52 degrees and extension to 21 degrees. She can lift 46 pounds and carry 41 pounds.

Request for 10 additional sessions of work hardening was not certified in review on April 15, 2009 with rationale that the patient was not recommended additional treatment by the DDE. Additionally, the patient had already entered a 10 sessions work hardening program with report on April 1, 2009 following the initial session that she was almost at her required lifting level of 50/25 pounds and was displaying 46/23 pounds. It was reasoned that the patient would sufficiently complete her rehabilitation in the following 9 sessions of work hardening.

Request for reconsideration for an additional 10 sessions of work hardening was not certified in review on May 27, 2009 with rationale that the medical records failed to document any significant progress with lifting after 10 sessions of work hardening. The provider noted the patient made excellent progress during the initial 10 sessions, but did not meet the demand level for returning to work. The amount the patient could lift on May 1, 2009 was the same as her initial testing on April 1, 2009. Additionally, the length of the program had exceeded guideline requirement of four consecutive weeks and the claimant had not undergone vocational training to ready her for return to work in the capacity she meets from work hardening.

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

The patient is overweight and slipped on a ramp at work. Lumbar MRI reportedly showed no acute process from the injury in October 2008. EMG of November 2008 showed evidence of chronic denervation at the right L3-4. The patient has pre-existing depression. She has attended 10 sessions of work hardening covering a four-week period. She has been noted to have progressed with exception of the lifting requirement for her job demand. After four weeks of work hardening she had not increased her lifting ability at all. However she has been very close to her required lifting demand since at least February 20, 2009. Per Designated Doctor opinions the patient is at MMI and is not likely to improve with future active medical treatment. There has been no rebuttal or additional medical rationale submitted from the provider to support the request. Additionally, it has been noted several times that, the patient has learned how to effectively cope with and tolerate pain. The medical records fail to document a medical necessity for additional formal work hardening. I would agree with the Designated Doctor opinions that this patient is MMI and is not likely to improve with further active medical treatment. Therefore, my recommendation is to agree with the prior non-certification for an additional 10 sessions of work hardening.

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 Chapter (6-23-2009):

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 have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), 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. 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.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment.

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.

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.

Outcomes measured: Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to "demedicalize" treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all.

Outcomes (in terms of body parts)

Neck and Shoulder: There are limited studies about the efficacy of chronic pain programs for neck, shoulder, or upper extremity musculoskeletal disorders. This may be because rates of cervical claims are only 20-25% of the rates of lumbar claims. In addition, little is known as to chronicity of outcomes. Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with cervical spine disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes. Cervical patients were statistically less likely to have undergone pre-rehabilitative surgery.

Multidisciplinary back training: (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the "graded activity" principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year's duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment.

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested.

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability.

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. There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be "at-risk" for post-discharge problems. 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) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain.

Timing of use: Intervention as early as 3 to 6 months post-injury may be recommended depending on identification of patients that may benefit from a multidisciplinary approach (from programs with documented positive outcomes).

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) 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) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.

(10) 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 they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in 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 (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a "stepping stone" after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.