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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/24/2010

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

10 sessions 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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a female who sustained an industrial injury on xx/xx/xx.

A July 2, 2008 functional capacity evaluation report notes that the patient is a business service representative placing her in a

sedentary physical demand characteristic level, which is defined as lifting 10 pounds or less. The report notes that the patient is currently performing lifts and carries at a physical demand characteristic level of sedentary which equates to her job. She showed several inconsistencies in testing and appeared limited only by subjective complaints of pain.

The patient underwent a designated doctor evaluation on August 29, 2008. The report notes that the patient works as a business access representative for a hospital. She registers and interviews emergency room patients. She reported that she got hit by an elevator door twice. The first time, she was hit on the left hand side but was able to walk out of the elevator without any trouble. She got hit again on the right-hand side and got a bigger "jolt," and that is when she reported the injury. In May 2008, a chiropractor performed physical therapy in the office 2 or 3 times per week and she continues to receive therapy. A July 2, 2008 functional capacity evaluation revealed physical demand characteristics of a sedentary person which was equal to that of the current job status. Despite that, she had not been released to work. MRI's of the bilateral shoulders on July 17, 2008 were unremarkable for the left side and demonstrated arthritis in the right shoulder. A cervical spine MRI from August 11, 2008 demonstrated no abnormalities except for some mild arthritis.

The patient was examined by the designated doctor and declared to be at maximum medical improvement with a whole person impairment of 0%. It was noted that she should be able to return to work on a full duty basis with no limitations. She showed no diagnosis-related impairment of the bilateral shoulders that would be ratable. Her diagnoses included cervical strain, thoracic strain, lumbar strain, and bilateral shoulder contusion.

The case was evaluated on February 27, 2009. The report notes that by June 16, 2008, 12 sessions of chiropractic care were completed with no noted improvement. The reviewer noted that the complaints have absolutely no objective basis whatsoever. It was noted in the report that the patient was voluntarily restricting her motions in an effort to inflate the impairment rating with the designated doctor and there was no pathology identified in the spine to warrant any impairment rating.

The patient was seen by the treating doctor on November 9, 2009 with complaints of bilateral shoulder pain, arm pain, neck pain, hand pain, and low back pain. Examination findings included tenderness in the cervical spine, slightly decreased cervical spine range of motion, sensation grossly intact, tenderness in the lumbar region, slightly decreased lumbar range of motion, negative straight leg raise bilaterally, intact reflexes, normal motor strength, painful range of motion and decreased range-of-motion in the bilateral shoulders with some crepitation, and slightly decreased range of motion of the bilateral wrists. She was advised to continue oral medications and an orthopedic consultation was recommended.

The patient was seen on December 14, 2009 and given a prescription for oral medications to include hydrocodone 7.5/500 mg tablets, #60, one tablet by mouth twice a day as needed; Lyrica 150-mg tablets, #60, one tablet by mouth twice a day; and Soma 350 mg, #60, one tablet by mouth twice a day. On January 25, 2010, it was noted that the orthopedic consult had been denied. In addition to the previously prescribed medication, the following were added: Ultram ER 300 mg tablets #30, one tablet by mouth a day and Cymbalta 20 mg tablets #60, one tablet by mouth twice per day.

The patient underwent a mental health evaluation on March 16, 2010. It was noted that she is not receiving workers' compensation benefits. She has a medical history of breast cancer that was diagnosed in August 2009. She is currently undergoing chemotherapy. She scored in the severe disability range on the Oswestry disability index. On the Beck Depression Inventory, she scored within the severe range. On the anxiety inventory, she scored within the moderate range. She scored in the high range on the Fear Avoidance Beliefs Questionnaire. She was diagnosed with pain disorder associated with both psychological factors and a general medical condition, moderate major depressive disorder, and GAF 58 (current). She was deemed an appropriate candidate for a comprehensive chronic pain management program. It was noted that she has been treated with physical therapy, medication and a brief course of individual psychotherapy. Despite these lower levels of care, she continues to report high levels of pain and has been unable to return to work.

On March 16, 2010, a work capacity evaluation was performed. It was noted that the patient's occupation requires a medium physical demand level and she is currently performing at a sedentary physical demand level. She passed the validity criteria giving her a good validity profile indicating maximum effort.

A March 22, 2010 preauthorization request notes that the patient has been treated with antidepressant medication. Medications were listed as hydrocodone, Ultram, Lyrica, and Soma. She has undergone individual psychotherapy and medication management with antidepressant medication of Cymbalta. She requires assistance with many of her regular activities of daily living. Physical activity exacerbates the pain.

The request was reviewed on April 12, 2010 and non-certified. The rationale indicates that the injured worker presents injuries that are not consistent with the reported mechanism of injury. Her psychological complaints have not been validated by use of a test such as the MMPI-2 that has validity scales that will determine the validity of the complaints. There was no record of individual psychotherapy and therefore no indication that lower levels of care have been exhausted.

An April 21, 2010 request for reconsideration notes that the patient has had antidepressant medication in the form of Cymbalta. She has been unable to bring her depression and anxiety to manageable levels and needs more aggressive intervention to control her depressive reaction. She needs specific pain and stress management training and significant vocational readjustment. Other treatment options have been exhausted.

The request was again reviewed on April 27, 2010 by another reviewer and non-certified. The rationale noted that the patient has had diagnostic, PT, IT, and medications. She is taking hydrocodone, Ultram, Lyrica, Soma, and Cymbalta. A March 16, 2010 work capacity evaluation notes that she is functioning at a sedentary physical demand level and requires a medium physical demand level. Her diagnosis is unclear. She reportedly had IT but her progress is not outlined. The physician reported that it appears that she has some neck bulges, mild shoulder effusion, and tendinitis. The legitimacy of CPMP for conditions was

apparently discussed with the requesting physician and it was unclear why the conditions would not have been resolved by now. The patient did not appear to have attempted to return to work recently or to reduce her medications.

The records include a May 5, 2010 letter from the physician which reiterated the information in the April 21, 2010 request for reconsideration. Several items in support of the medical necessity for a chronic pain management program were provided. The report notes that the average pain level is 8/10. She needs to learn alternative methods of controlling pain and diminishing dependence on analgesics. She currently takes hydrocodone, Ultram, Lyrica, and Soma. She has undergone lower levels of psychological intervention with individual psychotherapy and medication management with Cymbalta. She has significant functional deficits.

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

It is noted that the patient was declared to be at maximum medical improvement as far back as August 29, 2008. In addition, at that time, it was noted that she had a whole person impairment of 0% and would be able to return to full duty with no limitations. A functional capacity evaluation from July 2008 had noted several inconsistencies in testing and that the patient appeared limited only by subjective complaints of pain. She was deemed to be at a sedentary physical demand level which was appropriate for her job. In February 2009, records were reviewed and an opinion was provided that there was no pathology for the spine to warrant any impairment rating and that the patient's complaints had absolutely no objective basis.

The above information is in contrast to that found on March 16, 2010 in a work capacity evaluation, which noted that the patient's occupation requires a medium physical demand level, with the patient's current physical demand level of sedentary. Because of these discrepancies, the records do not establish that the patient has significant objective physical impairments to warrant consideration for a current chronic pain management program.

It should also be noted that the guidelines suggest that a predictor of success and failure is a high level of psychosocial distress and increased duration of pre-referral disability time. Both of these predictors apply to this patient. The patient demonstrated evidence of moderate anxiety, severe depression, high fear avoidance, and severe disability upon testing on March 16, 2010. Further, it is noted in the records that the patient has had some extent of individual psychotherapy. However, the records do not elaborate upon the number of completed sessions, type of psychotherapy administered, and precise outcome. Based on this information, the records do not establish that the patient has adequately exhausted lower levels of care for her psychological conditions. Therefore, my determination is to uphold the decision to non-certify 10 sessions of a 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

According to the Official Disability Guidelines: Pain Chapter

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 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.

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) 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. (Proctor, 2004) 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. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) (Dersh, 2007)

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.