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

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 02/18/2011

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 (Board Certified), 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 CMPC for the right ankle over 2 weeks including #97799

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 and prior reviews the patient is a xx-year-old male who sustained an injury to the right ankle when a piece of equipment fell on him. The ankle was fixated and repaired and hardware was later removed in March 2009. He underwent a surgery on October 1, 2010 for right subtalar joint arthrodesis.

An operative report dated March 8, 2009 describes surgery with removal of painful hardware from the right tibia, excision of excessive callus. The patient has a history of tibia fibula fracture fixated with a plate. He has since healed his fracture with an abundant amount of callus. He has now significant painful callus as well as painful hardware that require operative removal.

Additional surgery was performed on October 1, 2010 with right subtalar arthrodesis and harvest of right proximal tibial bone graft.

Orthopedic examination dated January 12, 2010 indicates the patient is being seen for a second opinion. He had a

crush injury to the right leg when equipment fell on him. He has had several surgeries on the right lower extremity. His biggest residual complaint is neuritic type pain into his hindfoot and plantar aspect of the foot but he also describes burning neuritic pain involving the entire extremity at night when trying to sleep. His next concern is swelling. He does well when wearing a double upright
brace. He has been encouraged to forego the brace but when he does not use the brace he has significant swelling and pain. He is 5' 8" and 206 pounds. He has decent strength and good stability at the right ankle. Multiple surgical incisions and traumatic scars are well healed. There is diffuse thickness and swelling to the right leg from the knee distally. There is no real warmth or erythema associated with this. He really does not have much sensation distal to the ankle. X-rays show a healed tibia fracture.
He has persistent hypertrophic nonunion of the fibula. All of the hardware has been removed. The ankle mortise is concentric. There is no evidence of any traumatic arthrosis of the ankle joint. He should continue to use the brace and use Lyrica. He would like to avoid any further surgery.

Operative report dated October 1, 2010 describes procedures of right subtalar joint arthrodesis and harvesting of right proximal tibial bone graft. An Aburak 6/7 screw was placed crossing the subtalar joint to stabilize and compress the joint. Sutures were removed and Steri-strips placed on October 15, 2010 and he was placed in a non-weightbearing short leg cast.

The patient was reevaluated six weeks post-op and noted to be doing well with minimal swelling and tenderness through the hindfoot. X-rays showed good early consolidation of the arthrodesis and no loosening of the single screw. He was placed in a short walking cast. In one month he will transition to unprotected weightbearing in a shoe. On December 14, 2010, at x months post-op the patient is pain-free with protected weightbearing. He relates some left knee pain. There is some expected postoperative swelling. He is completely non-tender through the hindfoot and ankle. He still has some tenderness through the lateral leg at this level of his chronic fibular nonunion. X-rays appear to show solid arthrodesis. Unprotected weightbearing in a regular shoe will be allowed. He will do strengthening with Therabands and use Celebrex. A new impairment rating will be scheduled.

FCE was performed on December 31, 2010. The patient has had a total of four surgeries on the right lower extremity. He states he had PT in early 2009, but has not had therapy since his last operation on 10/01/10. He relates pain of 6/10 at the bottom of the foot and 3/10 at the right lateral ankle that increases to 8/10, 4/10 respectively with walking. He is currently unemployed. He needed to occasionally lift 40 pounds. He limps when walking and wears a boot/brace on his right foot/lower leg. He was given the boot that he is wearing this visit and a shoe-brace from his orthopedic provider that he does not wear as it does not fit him with foot and ankle swelling. He wears a compression sock. He is unable to squat with his boot/injuries. Active right ankle ROM was tested and shows 10/20 degrees of PF, 7/10% of DF, 2/20 degrees of INV and 1/10 degrees of EVR. His lifting capacity is 30 pounds floor to waist (Medium PDL) and 12 pounds for shoulder to overhead (less than Sedentary). He has "exhausted (sic) all lower level modalities." His lifting capacity does not meet his job requirement. He has ROM difficulties. He is not functioning at a level to return to either job safely and he has chronic pain issues that have not been resolved. The patient is recommended for a CPMP of 10 days.

The patient was evaluated psychologically for a CPMP on January 3, 2011. He rates his pain as 8/10 prior to medication and also with medications. He does not smoke and has no prior mental health issues or treatment.
He does not sleep well and sleeps about 3 hours nightly. He has mild depression per BDI testing (score of 14) and moderate anxiety per BAI testing (score of 32). He has a chronic pain disorder with inadequate coping skills. He is recommended for a CPMP.

Request for a CPMP was made per report dated January 5, 2011. The patient remains off work and is unable to return to work due to his physical disabilities. He is using Celebrex. He has a chronic pain syndrome. He has had four ankle surgeries and now has a solid ankle arthrodesis per x-rays. He depends on his family for support and is unable to do chores. He has depressed mood. He has withdrawn from social activities. His function has not been restored. He has poor sleep. He is using Celebrex. Medication contract dated January 5, 2011 indicates the patient is using Celebrex.

Request for precertification dated January 5, 2011 indicates the requested CPMP will be 10 sessions, 8 hours daily, and five days per week for two weeks.

Request for 10 sessions of CMPC for the right ankle over 2 weeks including #97799 was considered in review on January 10, 2011 with recommendation for non-certification. A peer discussion was attempted but not realized. An assistant stated that per the FCE, the patient needs post-op PT, which should already have been done. The request for CMPM was withdrawn. The ankle was fixated and repaired and hardware was later removed in March 2009. He underwent a surgery on October 1, 2010 for right subtalar joint arthrodesis. He was placed in a cast. On December 14, 2010 he was diagnosed with a chronic subtalar nonunion but was cleared to wear a shoe. On December 28, 2010 a pain management program was recommended. He had a FCE on December 31, 2010 and the evaluator stated he had exhausted all lower level modalities and he recommended a chronic pain management program (CPMP). He had a psychological evaluation on January 3, 2011. Rationale for denial notes there is no evidence that this patient has completed lower level therapy since his ankle surgery of October 1, 2010. It is unclear whether the CPMP is medically necessary. The patient has not yet completed a course of post-op PT. The provider's assistant agreed and she has withdrawn this request pending additional treatment.

Request was made for reconsideration per letter dated January 14, 2011. In regard to previous methods of treating chronic pain, the patient has previously treated with PT, E-stim/TENS, injections and four surgeries. The patient did not participate in post-op PT due to his surgery being a joint fusion. He will not obtain ROM in his ankle and it would be redundant to participate in active PT program knowing this. He needs a multidisciplinary program not only to address his pain but also to address his medication usage and his severe levels of anxiety. He needs coping skills and does not have any negative predictors of success. He is motivated to change. A medication contract (for Celebrex) is attached.

Request for reconsideration 10 sessions of CMPC for the right ankle over 2 weeks including #97799 was considered in review on January 20, 2011 with recommendation for non-certification. A peer discussion was attempted but not realized but an assistant provided additional information. Per the reviewer, the patient had a work injury and developed right foot pain. No physical findings were submitted. He has apparently undergone four surgical procedures on the right foot, the most recent being a fusion. Although he had undergone physical therapy previously, he has had none since the fusion. There is no evidence that this patient has lower level therapy since his ankle surgery on 10/1/10. It is unclear whether the CMPM is medically necessary. It has not been shown that conventional physical therapy would not be successful. In fact, no such therapy has been tried. It would be exceptional to go straight from surgery to a multidisciplinary pain treatment program without trials of less intensive rehabilitation. Furthermore, no physical examination report ruling out condition requiring prior to initiating the CPMP was submitted.

Request was made for an IRO.

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

ODG: CPMP are 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."

The most current physical examination from the provider on December 14, 2010 notes the patient is pain-free with protected weightbearing 2.5 months post-op. He relates some left knee pain. He will do strengthening with Therabands. The FCE report of December 31, 2010 noted pain of 6/10 at the bottom of the foot and 3/10 at the right lateral ankle that increases to 8/10, 4/10 respectively with walking. He limps when walking and wears a boot/brace on his right foot/lower leg. He was given the boot that he is wearing this visit and a shoe-brace from his orthopedic provider that he does not wear as it does not fit him with foot and ankle swelling. He wears a compression sock. He is unable to squat with his boot/injuries. Active right ankle ROM was tested and shows 10/20 degrees of PF, 7/10% of DF, 2/20 degrees of INV and 1/10 degrees of EVR. There is no follow-up clarification as to how the patient is doing in regard to an ill-fitting shoe brace or whether he is still using the boot/brace. The patient does have some ROM at his ankle and ankle strength is not reported. Post-op PT could be useful to the patient for pain control, improved gait, and strength. The patient's progress with strengthening with Therabands is not reported. The patient also does not have any medications issues and is only using Celebrex with no report of adverse effects. It is also noted that, in the initial peer discussion attempt on January 10, 2010 the provider's assistant stated the request for CMPM was withdrawn as the patient had not attended any post-op PT as recommended by the FCE. Without attending lower level therapy, the patient could not be substantiated as having a delayed recovery. Considering all these facts, therefore, my recommendation is to agree with the previous non-certification for 10 sessions of CMPC for the right ankle over 2 weeks including #97799.

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

The Official Disability Guidelines 02-09-2011 Pain Chapter - Chronic Pain Management 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. 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.

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.

Intensive multidisciplinary rehabilitation of chronic low back pain: The most recent Cochrane study was withdrawn from the Cochrane (3/06) as the last literature search was performed in 1998. Studies selected included a physical dimension treatment and at least one other treatment dimension (psychological, social, or occupational). Back schools were not included unless they included the above criteria. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function when compared to inpatient or outpatient nonmultidisciplinary rehabilitation. Intensive (> 100 hours), daily interdisciplinary rehabilitation was moderately superior to noninterdisciplinary rehabilitation or usual care for short- and long-term functional status (standardized mean differences, -0.40 to -0.90 at 3 to 4 months, and -0.56 to -1.07 at 60 months). There was moderate evidence of pain reduction. There was contradictory evidence regarding vocational outcome. Less intensive programs did not show improvements in pain, function, or vocational outcomes. It was suggested that patients should not be referred to multidisciplinary biopsychosocial rehabilitation without knowing the actual content of the program.

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus ether 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. (Karjalainen,

2003)
Role of opioid use: See Chronic pain programs, opioids.

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. (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.

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).
Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals.

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). See Chronic pain programs, early intervention.

Role of post-treatment care (as an outcome): Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a "new provider" is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed.

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) W ithdrawal 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 (80 hours) 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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(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). (Sanders, 2005) 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).