

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: 03/22/2011

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 (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 - additional 80 hours

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 12-13-10 Report from Dr. DC
- o 12-14-10 Report from Dr.
- o 01-05-11 CPMP - fact sheet - modalities and treatments provided
- o 01-05-11 Invoice for one session of CPMP
- o 01-10-11 Letter from Dr. DC
- o 01-11-11 Diagnostic Screening from Dr.
- o 01-18-11 Adverse Determination Notice
- o 02-01-11 Diagnostic Screening from Dr.
- o 02-01-11 Report from DC -Request for additional
- o 02-10-11 Request for Reconsideration from Dr.
- o 02-19-11 Adverse Determination after Reconsideration Notice
- o 03-02-11 Request for IRO from the Claimant
- o 03-03-11 Confirmation of Receipt of Request for IRO from TDI
- o 03-04-11 Notice to of Case Assignment from TDI
- o 03-10-11 Attorney response to request for IRO.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury on

Xx/xx/xx when she fell on the sidewalk in front of her place of employment. The patient attended chiropractic treatment, acupuncture, and had epidural injection and medication management. She then was approved for a chronic pain management program (CPMP). The initial requested program was to consist of 10 sessions over two weeks. After attending 30 sessions of the CPMP she had a sick child at home and did not complete the sessions. Another 80 sessions were approved on September 28, 2010 (total 110 sessions). It has been reported that there was agreement that the additional 80 hours approved for CPMP would be the final and concluding treatment for this case.

Provider letter dated December 13, 2010 indicates the patient recently started a CPMP. She initially presented with cervical pain, upper extremity pain and muscle spasms and a pain level of 8/10. With a few weeks of CPMP she has reduced her pain levels to 5-6/10. She also notes 30% improvement in ROM. She has been out of work for several months. She was not able to finish the CPMP due a sick child. She is requested to complete the CPMP.

The patient was examined on December 14, 2010. She is participating in a CPMP. She has been accepted with and has a counselor and is also a student at a local college. She has a specific vocational plan she is working on. Because she is attending college, she is not able to do CPMP full time. Her treatment has included x-rays, nerve studies, MRI, chiropractic examination and treatment, rest, PT, epidural injections, acupuncture, and medication management. She is making good progress in the CPMP. She is divorced and lives with her parents and son. She has a diagnosis of cervicobrachial syndrome, cervicgia and multiple cervical subluxations as well as a psychological diagnosis of Pain Disorder and Depression Disorder. Her current GAF is 58. The patient was approved for 80 hours of the CPMP. She was unable to complete all 80 hours due her college program. The team is asking for an extension to February 2, 2011 to allow her to complete the CPMP.

Invoice dated January 5, 2011 indicate the patient is attending a CPMP. The invoice is for \$1,140.00. It appears to be for one visit. The program includes physical conditioning, biofeedback relaxation training, acupuncture, patient education and group therapy.

Letter from the treating provider dated January 10, 2011 indicates the patient recently started a CPMP program. She initially presented with cervical pain, upper extremity pain and muscle spasms. Her initial pain score was 8/10. With "a few weeks" of pain management her pain has been reduced to 5-6/10 and her ROM has been improved 50%. She was not able to finish the CPMP due a sick child, which caused her to miss some of the hours. Request is for the patient to finish the CPMP she recently started. Even though measurable improvements have been noted, she is still functioning below a safe level for return to work. Cervical flexion is 30/45 and extension 20/55. She has positive right foramina compression test and positive right shoulder depressor test. She has high pain levels and decreased range s of motion. She also has emotional symptoms. She could benefit from completing the CPMP she started. Request is for an additional 40 hours.

CPMP reassessment was performed on January 11, 2011. The patient had (an additional) completed 80 hours of the CPMP. She has discontinued Soma and uses 1 Hydrocodone daily and 1 tablet of Elavil daily. She plans to taper all narcotic medication. Her pain has been reduced from 8/10 to 5-6/10. Her Pain Experience score has been reduced from 82 to 57. She feels she has learned tools to deal with her chronic pain. She initially reported severe pain and currently reports moderate pain. Her McGill Pain score was reduced from 4/5 to 3/5. Her depression score has been reduced from 33 to 18 and her anxiety score from 37 to 23. Her sleep disturbance was moderate and is currently mild. Focus will now be on career planning and physical endurance and strength. The patient is highly motivated for further improvements. The patient now realizes her problems and/or disabilities are very much permanent but she plans to work in spite of them. She has a diagnostic impression of Depressive Disorder and Pain Disorder and cervicobrachial syndrome, cervicgia and multiple cervical subluxations. The team is requesting she participate in an "additional 80 hours of CPMP." It is expected she will continue to improve during "an additional 40 hours, transition appropriately into an active daily living lifestyle and return to some form of gainful employment." The treatment goals are outlined.

The patient was assessed on February 1, 2011 by her chiropractic provider for additional hours in the chronic pain management program (CPMP). She is currently functioning at a Sedentary category and she needs to be at a Medium category for return to work. She has attended several weeks of the CPMP and her pain levels have been reduced from 8/10 to 5-6/10. Her ROMs have also improved 50%. She was not able to complete the approved hours due a sick child at home. Request is for the patient to finish the CPMP she recently started. Examination shows abnormal sensation in the right C6 dermatome. Spinal percussion is positive at C6 and C7. Right shoulder depression is positive. Right foraminal compression test is positive. Specific request is for "40 hours of CPMP", which will allow her to finish the program, finish her DARS training and return back to work.

The patient was reevaluated following completion of 80 hours of a CPMP on February 1, 2011. She is using 1 tablet of Hydrocodone daily and one tablet of Elavil nightly. Soma has been discontinued. Her tapering goal is to discontinue the use of any narcotic medication by the end of the next 80 hours of treatment. She has attended daily group psychotherapy and weekly individual psychotherapy. Her pain has been reduced from 8/10 to 6/10. She reports some continuing achy pain in the low back and left hamstring. The pain experience score has been reduced from 82 to 57. Her Revised Oswestry low back pain disability questionnaire core has been reduced from severe to high moderate. The McGill Pain Short form score is now 3/5 and used to be 4/5. She is adapting and using coping skills learned in the program. The BDI score has been reduced from 33 to 19 and she now has mild depression. Her BAI score has been reduced from 37 (severe anxiety) to 20 (low moderate anxiety). In the next 80 hours focus will be on career planning and further improvement of her physical capacity. She continues to contend with moderate to severe pain levels and physical limitations. The proposed program is 6-8 hours daily, five days per week for 80 hours.

Request for additional chronic pain management was considered in review on January 18, 2010 with recommendation for non-certification. A peer discussion was conducted. Rationale states the request does not meet preliminary guidelines. The patient is age 40 and has multiple complaints associated with an injury of 7 years prior. After attending 30 sessions of a CPMP another 80 sessions were approved on September 28, 2010 with provision that "another 80 hours of CPM will be the final and concluding treatment for this case." Guidelines indicate that treatment beyond 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.

Request for reconsideration additional chronic pain management was considered in review on February 9, 2011 with recommendation for non-certification. Per the reviewer, the claimant has already been approved for 110 hours (30 + 80) of CPMP. ODG states treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by the subjective and objective gains. The employee did not attend all the sessions approved. She is currently working with DARS toward employment. Finally, it was agreed with the last approval that no additional sessions would be requested.

Request was made for an IRO.

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

Per ODG criteria for CPMP are noted below. Of note, the patient should have 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.

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 improvement 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).

The patient attended 30 hours of the CPMP and did not attend further due a sick child at home. She was approved for an additional 80 hours of CPMP, which she has completed (total 110 hours). Current report is for an additional 80 hours of CPMP (total 190 hours). There also appears to be an aftercare plan in the works to considered her for an additional 40 hours for transition into an active daily living lifestyle and return to some form of gainful employment (total 230 hours). It is noted also that the February 1, 2011 report appears to request an additional 40 hours of CPMP (total 150 hours), a request which could have been given greater consideration. However, the current requested treatment is for an additional 80 hours. The patient appears to have benefited with the 110 hours of CPMP attended. She is attending college and has a clear vocational goal. She is only using Hydrocodone and Elavil at this time. She cannot be said to have a significant loss of function or to be withdrawn from normal contact with others. Medical records fail to support the medical necessity for CPMP treatment duration in excess of 160 hours. In addition, there is no clear explanation why improvement cannot be achieved without an extension of the program.

Therefore, my recommendation is to agree with the previous non-certification for additional chronic pain management.

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 03-03-2011 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. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition.

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 (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).

(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.

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. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs