

**DATE OF REVIEW:** December 24, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic pain management program-knee, 5 times weekly for 2 weeks.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.O., duly licensed in the State of Texas. The reviewer has completed an Anesthesiology residency followed by a Fellowship in Pain Management, and is Board Certified in Anesthesiology with certificate of added qualifications in Pain Medicine. The reviewer has over 20 years of clinical experience in the specialty of Chronic Pain Management and is on the DWC Approved Doctor List, Level II.

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

A chronic pain management program for the knee, five (5) times weekly for two (2) weeks is not medically necessary in this case.

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI case assignment
2. URA letters of denials (08/06, 08/20, 10/26, 11/19/07) & criteria utilized in the denial-ODG
3. Report of Medical Evaluation 05/31/07
4. Evaluation and Physical Performance Exam 07/24/07
5. Treatment summary 10/03/07
6. Examination findings 10/09/07
7. Request for an appeal 11/07/07

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This claimant was injured on xx/xx/xx when his right knee gave out, causing him to fall forward, injuring his right shoulder and right elbow. An Independent Medical Evaluation performed on May 31, 2007 found the claimant at maximum medical improvement with a 4% whole person impairment rating. A Functional Capacity Evaluation performed on June 13, 2007 as part of that evaluation found the claimant fully capable of safely functioning at a heavy physical demand level, and that the claimant was capable of an eight-hour workday at that demand level with appropriate restrictions for frequent climbing and squatting. The examiner further pointed out that his examination documented no sensory deficit or motor deficit of the right upper or lower extremities, and no diagnosis-related impairment of the right shoulder, right elbow, or right knee. Prior imaging studies from January 10, 2006, were reviewed at that time, demonstrating a full thickness tear of the rotator cuff of the right shoulder, along with multiple degenerative changes within the shoulder. A right knee MRI showed a complex lateral meniscus tear but “no evidence of medial meniscus tear.” However, a right shoulder arthrogram on January 25, 2006, was entirely normal. Physical examination documented the claimant’s height as 74 inches and weight as 265 pounds. It was also noted the claimant had a history of diabetes and hypertension. The examiner recommended a second orthopedic evaluation due to the claimant’s continuing complaint of right knee pain. He noted that he had previously made such a recommendation but

it had still not yet occurred. He further stated that it was “unlikely” that the claimant would have any significant improvement from his current status unless such a repeat orthopedic evaluation was performed.

On July 24, 2007, the claimant was seen for evaluation of admission into a chronic pain management program. At that time it was noted that the claimant had undergone right shoulder arthroscopy and left knee arthroscopy with medial meniscus repair, even though the MRI from January 2006 apparently demonstrated no such pathology. He also noted the claimant had “periods of rage” and that he was abusing alcohol “since he stopped taking medications.” However, he also noted that despite the statement that the claimant had stopped taking medication “approximately five months prior to this date,” the claimant was still taking Darvocet 5 times daily and Flexeril twice daily. The examiner noted the claimant consumed one-fifth of whiskey per week. He assessed the claimant with a possible recurrent medial meniscus tear and stated that he was status post right shoulder arthroscopy with rotator cuff repair; however, he made no mention of the claimant needing to undergo orthopedic evaluation. His plan was to admit the patient to a chronic pain management program to “optimize his analgesic medication” and to “attempt to reduce this patient’s alcohol consumption.” Nevertheless, despite urging that the claimant “cease the consumption of alcohol in the presence of narcotics,” the physician prescribed the claimant hydrocodone, Flexeril, and Prilosec. He also stated that the claimant would be discharged from his care “should any urinalysis result in a positive test for alcohol.”

A “psychologic evaluation” of the claimant also on July 24, 2007, but made no mention of the claimant’s ongoing alcohol abuse. He also stated the claimant was “not taking any medications for his injury” despite the prescriber’s documentation otherwise. He noted the claimant’s pain level as 6/7 out of 10 and stated that the claimant’s only “maladaptive coping strategy is trying to physically function and aggravate his pain.” He again failed to mention anything about the claimant’s alcohol abuse. He stated that there were no other psychological barriers which would interfere with the claimant’s treatment, again ignoring the clearly obvious problem of alcohol abuse. The individual conducting the psychological evaluation then recommended the claimant be admitted for ten sessions of a chronic pain management program.

Finally, a physical performance evaluation was performed by a chiropractor on that same date. In the evaluation, the chiropractor noted the claimant was only capable of a work capacity of light to medium, despite the fact that two months before, the claimant had tested at a heavy physical demand level when independently evaluated. A physician reviewer, on August 6, 2007, recommended non-authorization on the requested chronic pain management program. A second physician reviewer recommended non-authorization on August 20, 2007. The claimant then completed four sessions of individual psychotherapy and was re-evaluated on October 3, 2007. In that evaluation, it was noted that the claimant’s global assessment of functioning had not changed at all, that his Beck Depression Inventory had changed only minimally, that his pain level was still exactly the same as it previously was, and that his activity level had only improved minimally.

On October 9, 2007, the patient was re-evaluated, reiterating that the claimant’s pain level was now 7/8 out of 10, worse than it had been when he was evaluated some two and a half months before. Physical examination was, almost word for word, identical. No mention was made of whether the claimant had made any progress in reducing alcohol consumption, but allowed the claimant to continue hydrocodone, now t.i.d., as well as Flexeril and Zantac.

On October 26, 2007, a third physician reviewer again recommended non-authorization of the chronic pain management program. On November 7, 2007, an appeal request was submitted, again stating that the claimant had “exhausted all appropriate healthcare” despite the fact that the claimant had still not had the recommended orthopedic evaluation. The doctor noted the

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claimant's pain level was still at 7/8 out of 10 despite continuing to use narcotic medication, still making no mention of the claimant's previously admitted alcohol abuse. A fourth physician reviewer, on November 19, 2007, reviewed the reconsideration request, again recommending non-authorization. Finally, on December 10, 2007, a request was made for the claimant to be admitted to a "chemical dependency intensive outpatient treatment" for "opiate dependence" at a frequency of three times per week.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

A chronic pain management program is not medically reasonable or necessary for treatment of a work injury unless all appropriate medical treatment and evaluation has been exhausted. This claimant, despite having apparently undergone right shoulder surgery and, according to the record, left knee surgery, still has significant pain, yet has not been re-evaluated by an orthopedic surgeon, nor had repeat imaging studies to determine whether or not there is any residual or recurrent pathology. Moreover, despite having completed four sessions of individual psychotherapy, the claimant had no reduction in his overall pain level, and the issue of his documented alcohol abuse was apparently not addressed.

Therefore, in this case, the criteria for admission to a chronic pain management program have not been met. This claimant has not exhausted all appropriate medical treatment and has demonstrated lack of response to psychologically-based treatment, treatment which, more importantly, apparently completely ignored the clear problem of documented alcohol abuse in his evaluation for admission to the chronic pain management program. Finally, the claimant has apparently been referred to an opiate dependency outpatient treatment program, which, again, indicates that the claimant has not exhausted all appropriate medical treatment prior to being considered for a chronic pain management program. The recommended non-authorization for ten sessions of a chronic pain management program, five times weekly for two weeks, is therefore upheld as being not medically reasonable or necessary in this case.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
  - AHCPH-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 judgment, 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 national accepted medical literature (provide a description).
  - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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