



Notice of Independent Review Decision

**DATE OF REVIEW: 02/05/08**

**Amended Date: 02/18/08**

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for chronic pain management program, 10 sessions.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

**REVIEW OUTCOME:**

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

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for chronic pain management program, 10 sessions.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- **Notice of Assignment of Independent Review Organization dated 1/28/08.**
- **Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 1/28/08.**

- **Request for a Review by an Independent Review Organization dated 1/18/08.**
- **Notification dated 12/20/07, 12/4/07.**
- **Fax Cover Sheet Message dated 1/18/08.**
- **Pre-Authorization Request dated 1/15/08, 12/13/07, 11/28/07.**
- **Medical Necessity Note dated 12/13/07.**
- **Psychotherapy Session dated 11/26/07.**
- **Functional Capacity Evaluation Results dated 10/31/07.**
- **Electromyogram and Nerve Conduction Studies Report dated 8/6/07. Narrative Report dated 1/7/08.**
- **Left Knee MRI dated 6/21/07.**
- **Psychodiagnostic Examination dated 8/24/07.**
- **Cover Sheet for Independent Reviewer dated 1/31/08.**

**No guidelines were provided by the URA for this referral.**

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years

**Gender:** Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Stepped on a roll of wire and fell backwards, twisting his left knee.

**Diagnosis:**

1. Status post left knee partial lateral meniscectomy.
2. Status post chondroplasty of the lateral tibial plateau.
3. Status post chondroplasty of the lateral femoral condyle.
4. Status post chondroplasty at the undersurface of the patella.

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

The patient is a xx-year-old male who sustained a work-related injury on xx/xx/xx, involving his left knee secondary to stepping on a roll of wire causing him to fall backwards, twisting his left knee. The patient was diagnosed with current diagnoses:

1. Status post left knee partial lateral meniscectomy.
2. Status post chondroplasty of the lateral tibial plateau.
3. Status post chondroplasty of the lateral femoral condyle.
4. Status post chondroplasty at the undersurface of the patella.

Following this claimant's injury, he underwent conservative treatment consisting of at least 12 weeks of physical therapy due to continued left knee complaints. The claimant had undergone a left knee MRI performed on June 21, 2007, which revealed mucoid meniscal changes in the anterior horn of the lateral meniscus and lateral tilt of the patella. An electromyogram (EMG) of the lower extremities revealed no evidence of spontaneous activity; recruitment patterns appeared to be within normal limits, as the waveform morphology. The claimant was evaluated by orthopedic surgeon, Dr., who performed left knee arthroscopy in October 2007. Following this, the claimant underwent postoperative physical therapy for an additional 12 weeks with improvement in his left knee pain. The claimant's last therapy was provided in November 2007.

Interestingly, the claimant underwent a psychological evaluation performed on August 24, 2007, approximately 2 months following his injury, with reported moderate amount of anxiety and depression. The claimant was reportedly treated with 6 sessions of individual psychotherapy; actually, 6 sessions of psychotherapy provided by Dr.. A required medical evaluation performed by, M.D. (orthopedic surgeon) on January 7, 2008, revealed that the claimant's left knee exhibited significant effusions and required aspiration. Once this has been performed, the claimant would be a good candidate for either a work hardening or work-conditioning program to help him prepare to return to the work force.

After review of the information submitted, the request for chronic pain management program has been denied. It is not clear to this reviewer whether all surgical interventions have been exhausted for this claimant's left knee issues. In addition, it appears premature that this claimant even underwent a psychological evaluation 2 months following his left knee injury. Nowhere in the medical records did this reviewer find anything more than an evaluation by a psychologist. There was no monitoring of this patient's depression or anxiety. There was no indication of what medications this patient had been taking related to his depression and/or anxiety.

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

**X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.**

Chapter 6, page 114. Pain-Pain management program components

While the components and approaches of multidisciplinary care often differ, the hallmarks of such programs include:

- Thorough, multidisciplinary assessment of the patient
- The establishment of a time-limited treatment plan with clear functional goals
- Frequent assessment of the patient's progress toward meeting such goals
- Modification of the treatment plan as appropriate, based on the patient's progress"

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 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. 5<sup>th</sup> Edition, 2006/2007 – Pain section – chronic pain program.**

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).