



## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/12/09

**IRO CASE #:**

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

Chronic Pain Management Program – 10 Sessions

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

Licensed Psychologist

### **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.

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

- Operative Report, M.D., 05/08/08
- Patient Re-Evaluation, M.D., 10/29/08, 11/19/08, 12/03/08
- Patient Re-Evaluation, D.C., 11/20/08, 01/28/09, 03/04/09, 04/17/09
- Right Knee MRI, M.D., 12/19/08
- Designated Doctor Examination, M.D., 01/20/09
- Physical Performance Evaluation, B.S., 03/04/09

- Request For Services, 03/05/09, 03/09/09
- Treatment – Requested Treatment Plan # 00010, R.N., 03/10/09
- Denial Letter, 03/13/09, 04/10/09
- Request for Reconsideration, 04/03/09
- Medical Management – Update, R.N., 03/12/09, 04/08/09
- Treatment – Not Authorized TX Plan 04/10/09
- Request for Medical Dispute Resolution, 04/23/09
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient underwent a right knee arthroscopic surgery and was seen in follow up visits. She was treated with Ultram for pain control.

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

In my medical opinion, chronic pain management program x 10 sessions is not medically reasonable and necessary.

The submitted records indicate that the patient slipped and fell on some slippery material while working on xx/xx/xx. The patient underwent right knee partial medial and lateral meniscectomy, removal of loose bodies, chondroplasty on 05/08/08. Postoperative treatment included physical therapy, oral medications, and bracing. The patient subsequently fell again and injured her right knee; however, repeat MRI reported no evidence of any additional significant injury, and only swelling and degenerative changes of the joint. The patient underwent a designated doctor evaluation (DDE) on 01/20/09. The patient was reportedly involved in a work hardening program at that time and reported that the program was helpful. The designated doctor recommended continued work hardening as well as a home exercise program. Patient reevaluation dated 03/04/09 indicates that the patient demonstrated significant gains in lower extremity strength as a result of the work hardening program; however, there is no comprehensive assessment provided with objective evidence of significant gains achieved in the work hardening program. A physical performance evaluation dated 03/04/09 indicates that the patient's current PDL is light. The patient's previous FCE was not submitted for review to establish the efficacy of the program and the patient's functional gains. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program such as chronic pain management program. The patient subsequently completed four sessions of individual psychotherapy and BDI improved from 33 to 25 and BAI from 30 to 23. The submitted records do not include a detailed psychological evaluation as required by the Official Disability Guidelines prior to enrollment in a chronic pain management program. It is apparent that the patient was provided the obligatory and minimal 4 sessions of individual psychotherapy, as the Official Disability Guidelines recommend an initial trial of 6 sessions, and the patient's Beck scales indicate significant improvement even without the use of psychotropic

medications, and given the progress achieved by the patient in individual psychotherapy, the rationale for discontinuing this treatment is unclear. The report dated 03/05/09 states, "since the date of her injury on xx/xx/xx, the patient has been suffering from anxiety, depression and muscular tension". There is no research that supports the immediate onset of depression or anxiety in an injury that was not traumatic. This report of anxiety and depression "since the date of her injury" casts doubt on the validity of the patient's reports as does the extremely elevated score on the L scale of the MMPI-2. Additionally, the submitted records do not establish that further invasive treatment has been ruled out, and the patient is an appropriate candidate for this tertiary-level program. The records provided do not establish that the patient has been consistently participating in a home exercise program as recommended by the designated doctor in January 2009. Given the current clinical data, objective and subjective findings, 10 sessions of chronic pain management are not medically reasonable and necessary.

**References:**

1. Official Disability Guidelines, Return To Work Guidelines (2009 *Official Disability Guidelines*, 14<sup>th</sup> edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp*, 7<sup>th</sup> edition) Accessed Online

**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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**