



Notice of Independent Review Decision

DATE OF REVIEW: 11/13/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for chronic pain management, additional 10 days (97799).

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

Texas licensed Physical Medicine and Rehabilitation/Pain Medicine Physician.

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, additional 10 days (97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 11/3/09.
- Independent Review Organization Sheet dated 11/2/09.

- Request Form dated 8/9/08.
- Request Letter dated 11/6/09.
- Treatment/Services Request/Letter dated 10/15/09, 9/17/09.
- Chronic Pain Daily Progress Note dated 9/9/09.
- Referral Form dated 7/9/09.
- Chronic Pain Management Program Pre-Authorization Request dated 10/8/09, 9/14/09.
- Case Information dated 9/14/09.
- Interdisciplinary Pain Treatment Components (unspecified date).
- Interdisciplinary Group Therapy Notes dated 9/9/09.,
- Chronic Pain Management Individual Psychotherapy Session dated 9/9/09.
- Functional Strength Deficit Summary dated 9/9/09.
- Functional Capacity Evaluation dated 9/9/09.
- Detailed Narrative Report dated 9/9/09.
- Chronic Pain Daily Flow Sheet dated 9/7/09.
- Continuation Request for 10 Final days of Interdisciplinary Chronic Pain Management Program dated 9/14/09.
- Discharge Summary dated 8/9/08.
- Environmental Intervention dated 10/15/09.
- History and Physical For Chronic Pain Management Program dated 3/16/09.
- Initial Behavioral Medicine Consultation dated 4/29/08.
- Radiology Report dated 4/8/09.
- Treatment History dated 11/6/09.
- Integrated Treatment/Disability Duration Guidelines dated 11/6/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: While kneeling down, his weight shifted and he felt a pop in his knee.

Diagnosis: Degenerative medial meniscus, severe osteoarthritis of the right knee.

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

This male sustained an industrial injury to his right knee on xx/xx/xx. At that time, he was wearing a right knee brace because of a pre-existing injury and osteoarthritis. The right knee brace was sufficient to support his right knee. On the date of injury, he was kneeling down on the right knee and his weight shifted in the brace. He felt a pop in his knee with associated right knee

pain. He underwent conservative treatment with physical therapy. He also underwent a right knee MRI scan dated August 28, 2008, demonstrating severe osteoarthritis, severe degenerative tear of the medial meniscus, joint effusion containing debris, small ganglion cyst in the popliteal fossa, prominent posterior osteophytes, and findings suggestive of arthrofibrosis. The claimant had completed three weeks of work hardening, however, he was unable to achieve the targeted physical demand level of very heavy, due to increased right knee pain and persistent functional deficits. He was subsequently authorized to undergo a chronic pain management program that was requested by Dr. on March 16, 2009. He subsequently completed 10 days of a chronic pain management program (97799), but did not achieve his goals and therefore, an additional 10 days was requested. This was previously denied twice and is now under an independent review. The Official Disability Guidelines for Workers' Compensation, Online Decision, Chapter: Chronic Pain, Chronic Pain Programs (Functional Restoration Programs) states: "And there are limited studies about the efficacy of chronic pain programs for upper or lower extremity musculoskeletal disorders." "Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

(1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; The patient has a significant loss of ability to function independently resulting from the chronic pain; Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. 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 these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program; At the conclusion and subsequently, neither re-enrollment in nor 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." Based upon the Appeal Letter of September 14, 2009 and subsequently, October 8, 2009, between the 10th day and the 20th day of the chronic pain management program, the claimant had demonstrated improved symptoms with regard to pain, irritability, frustration, tension and anxiety, however, the following parameters had significantly increased-depression by 25% and sleep disturbance by 50%. Additionally, the parameters that remain unimproved-depression and sleep disturbance, are indicative that the chronic pain management program was not successful and therefore continuation is not medically justified as the claimant can receive behavioral medicine management at a lower level of care intensity for these residual problems. In summary, the requested 10 additional days of a chronic pain management program (97799) remains unauthorized because the claimant had not demonstrated sufficient progressive benefit to medically justify this request. Although the claimant had demonstrated some behavioral improvement, ongoing behavioral medicine intervention can occur at a lower level of care-outpatient psychotherapy sessions rather than a chronic pain management program. Additionally, the claimant had not demonstrated any reduction in medication use and would not be capable of resumption of very heavy-duty usual occupational duties upon completion of the additional 10 days of the chronic pain management program (97799), due to his right knee severe degenerative condition with the meniscal tear and underlying right knee internal derangement.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Pain-Chronic pain programs.
- 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).