



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 03/29/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Outpt Pain Management 5 x wk x 2 Wks 80 hrs 97799 Rt Knee

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

Board Certified Physical Medicine & Rehabilitation
Fellowship Trained Pain Management

REVIEW OUTCOME

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

Denial Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. MRI of the right knee dated 12/18/08
2. Clinic notes dated 05/29/09-02/05/10
3. Prior reviews dated 02/10/10 and 03/12/10
4. Letter of reconsideration dated 03/03/10
5. Cover sheet and working documents
6. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx.

An MRI of the right knee dated 12/18/08 reported evidence of large joint effusion and medial meniscus tear.

The initial behavior medicine evaluation dated 05/29/09 reported the employee was injured while attempting to remove stilts resulting in a fall on his left side. The employee reported that he turned his right knee in the process of falling with immediate onset of pain.

The notes report the employee underwent arthroscopic surgery on 03/17/09. The employee complained of 6/10 pain. The note reported the employee had a BDI-II score of 20 and a BAI score of 27. The employee was recommended for six sessions of individual psychotherapy.

A clinic note dated 07/21/09 reported the employee had 130 degrees of active right knee flexion and 0 degrees of active right knee extension.

A clinic note dated 11/10/09 reported the employee "failed" two weeks of work hardening secondary to knee pain.

Psychological testing results dated 12/03/09 report the employee has a BDI-II score of d15 and a BAI score of 31. The Battery for Health Improvement-II results indicated the employee had high levels of anxiety and depression. The employee was administered the MMPI-II-RF with valid results. The employee was recommended for a chronic pain management program.

A Physical Performance Evaluation dated 02/03/10 reported the employee had a current physical demand level of medium and required a physical demand level of heavy to return to full duty.

A clinic note dated 02/05/10 reported the employee had almost completed ten sessions of a chronic pain management program. The note reported that the employee had a reduced pain rating score and a reduced BDI-II score. The employee was recommended for an initial ten days of a chronic pain management program.

A prior review dated 02/10/10 reported the request for continued chronic pain management program sessions was denied secondary to lack of significant improvement with prior sessions.

A letter of reconsideration dated 03/03/10 reported the employee had evidence of 20% - 40% reduction in almost every active symptom area when rated on a visual analog score. The note reported the employee had improved his physical demand level from light/medium to medium. The employee was again recommended for ten sessions of a chronic pain management program.

A prior review dated 03/12/10 reported the request for ten additional sessions of a chronic pain management program was denied secondary to minimal improvements.

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

The request for ten additional days of a chronic pain management program is medically necessary. Clinical documentation submitted for review indicates the employee has completed ten prior sessions of a chronic pain management program to date. The employee has reduced his pain rating and psychometric scores. The employee is also noted to have improved his physical demand level with prior treatment. Official Disability Guidelines state that "Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains." Clinical documentation submitted for review demonstrates that the employee has made objective and subjective gains with prior treatment. As such, the medical necessity for the request for a chronic pain management program for ten days has been established at this time.

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

Official Disability Guidelines, online version, Pain Chapter

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 examination 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.

(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).