

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: March 24, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 visits of PRIDE Chronic Pain Functional Restoration Program.

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

Diplomate, American Board of Anesthesiology
Diplomate, American Academy of Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Employers First Report of Injury or Illness, 10/07/08
- Texas Workers' Compensation Work Status Report, 10/08/08, 10/16/08, 10/22/08, 10/27/08, 10/30/08, 11/05/08, 11/12/08, 11/17/08, 12/08/08, 12/09/08, 01/12/09, 01/07/09, 01/09/09, 02/11/09, 03/11/09, 09/04/09, 02/03/10, 02/22/10
- Medical Group, 10/08/08, 10/16/08, 10/22/08, 10/27/08, 10/29/08, 10/30/08, 11/05/08
- Imaging, 11/04/08
- MRI Central, 11/12/08
- Orthopedic Center, 11/12/08, 11/17/08, 12/08/08, 01/07/09, 01/19/09, 02/11/09, 03/11/09

- xxxxxx, 12/02/08
- M.D., 12/09/08, 01/12/09, 01/21/10
- L.O.T/C.H.T, 04/02/09
- DWC-69, Report of Medical Evaluation, 08/04/09
- Medical Evaluators, 08/04/09
- Benefit Review Conference Report, 08/27/09
- M.D., 01/20/10, 01/22/10, 02/01/10, 02/24/10
- , 01/20/10
- Diagnostic Imaging, 01/21/10
- M.S., L.P.C., 01/22/10
- Ph.D., 01/22/10
- M.D., 01/28/10
- Specialty, 01/29/10, 02/09/10
- M.D., 02/09/10
- Texas Department of Insurance, 08/27/09
- Request for Approval of Chronic Pain Program, 01/25/10, 02/02/10
- Supplemental Report of Injury, 10/27/08, 10/29/08, 03/12/09, 02/04/10

Medical records from the Treating Doctor/Provider include:

- , 01/20/10, 03/10/10
- M.D., 01/20/10, 01/22/10, 02/01/10, 02/09/09, 02/24/10
- Diagnostic Imaging, 01/21/10

PATIENT CLINICAL HISTORY:

The description of services in dispute is ten visits of chronic pain functional restoration program. The review outcome: Upheld previous non-authorization.

This is a female who sustained a work-related injury on xx/xx/xx, involving the left knee, right elbow and shoulder. The patient reportedly got her shoe caught under a picnic table, causing her to fall.

Subsequent to the injury, the patient underwent conservative treatment consisting mainly of physical therapy.

An MRI of the left knee revealed internal derangement. An MRI of the right shoulder revealed impingement syndrome. An MRI of the right elbow was negative.

The patient subsequently underwent a left knee arthroscopy/repair on December 2, 2008. The patient completed postsurgical physical therapy.

There was a designated doctor evaluation performed on August 4, 2009. There was a report of continued complaints of left knee pain, rated via score of 3 out of 10, and right shoulder pain affecting the glenohumeral joint and extending to the lateral aspect of the upper arm, graded at 2 out of 10. There were no complaints involving the right elbow

pain. Of note, the patient had continued complaints reportedly from the initial date of injury involving the right knee. This extremity was currently being violated by the designated doctor. At the end of the report, which is performed by M.D., he opined that the extent of the employee's compensable injury based on history, review of records, and examination included the following areas: right shoulder, right knee and right elbow. The patient was not placed at maximum medical improvement and no impairment was given.

Subsequently, a right knee MRI was performed on January 21, 2010. This study revealed changes of presumed extensive partial medial meniscectomy and no definite evidence of meniscal remnant tear. There was moderate-to-severe medial femorotibial osteoarthritis. There was mild lateral femorotibial and patellofemoral osteoarthritis.

Of note, the patient had a right knee surgery performed back in 1991. The patient's right knee was part of the compensable injury via Benefits Review Conference with a right knee sprain/strain. Per the notes submitted, it is not clear whether the patient has completed any type of conservative treatment involving the right knee injury.

The patient's treating physician, M.D., is proposing the patient enroll in a functional restoration program in order to avoid surgery involving the right knee. The patient reportedly is a candidate for surgery due to severe knee arthritis (a disease related to an aging process, not a single event work injury). The patient does not wish to proceed with surgery.

A mental health evaluation performed on January 22, 2010, reports that anxiety and depression were not clinically elevated. The current medication management consists of an over-the-counter anti-inflammatory.

In addition, it appears that the patient is currently working.

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

After a review of the information submitted, the previous non-authorization for ten visits of the PRIDE chronic pain functional program has been upheld. It is not clear to the reviewer how reportedly the patient's biliation involving the right knee integrity would be improved with a chronic pain management program. The stated goals related to chronic pain management program are "coping" and control of diagnosed emotional and behavioral sequelae of the pain problem are not empirically supportable. This focus is specifically proscribed in this type of patient because such a strategy "may reinforce psychological, environmental, and psychosocial factors" that promotes "chronic pain states." Finally, the main purpose of these programs is to return patients back to work and wean off patients from sedative medications. Therefore, in accordance with ODG Guidelines, there does not appear to be sufficient reasons to overturn the prior adverse determination.

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)