

DATE OF REVIEW: MAY 28, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional 80 hours of Chronic Pain Management Program as outpatient, bilateral knees.

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

The physician reviewing this case is American Board Certified in Anesthesiology with a secondary specialty in 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)

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

On April 25, 2008, X-rays were taken of the left knee, read by M.D. Impression: Normal left knee.

On April 25, 2008, X-rays were taken of the right knee, read by , M.D.
Impression: Mild soft tissue swelling is present. There is no evidence of fracture, foreign material or a joint effusion.

On May 7, 2008, MRI of the right knee was taken, read by , M.D. Impression:
Normal examination.

On December 8, 2008, MRI of the left knee was taken, read by, M.D.
Impression: There is a horizontal type tear of the posterior horn of the medial meniscus involving the red-red and red-white zones. This extends to the tibial articular surface. The lateral meniscus demonstrates no definite meniscus tear. A Baker's cyst measures approximately 6.8cm in greatest dimension. The cruciate and collateral ligaments are intact. There is minimal capsular fluid. There is no fracture or dislocation.

On January 28, 2009, per the operative report, M.D. performed a left knee arthroscopy with excision of medial plica.

On July 2, 2009, M.D., a pain management physician, evaluated the claimant. Claimant reports a 7/10 on the VAS scale. Medications: Advair, Iron tablets, Ibuprofen, and Hydrocodone. Prescriptions: Xodol 10/300. Diagnosis: Left hip pain and bilateral knee pain.

On July 23, 2009, X-rays were taken of the lumbar spine, read by M.D.
Impression: There is no evidence of fracture or dislocation. The coccyx is poorly seen on this examination and if symptoms persist in the region of the coccyx a dedicated examination of the coccyx should be considered.

On July 23, 2009, X-rays were taken of the pelvis, read by, M.D. Impression:
There is no evidence of fracture. The bilateral SI joints and hip joints are unremarkable.

On August 3, 2009, M.D., a pain management physician, performed a follow-up examination on the claimant. Medications: Advair, Iron tablets, Ibuprofen, and Hydrocodone. Prescriptions: Xodol 10/300 and Ambien CR 6.25 mg.
Diagnosis: Left hip pain and bilateral knee pain.

On October 23, 2009, , Ph.D., clinical psychologist, performed an examination on the claimant. Impression: Pain Disorder Associated with both Psychological Factors and a general medical condition. Knee joint pain and neuropathy of the bilateral lower extremities.

On February 10, 2010, D.C. requested additional chronic pain management session. Rationale: "I believe that a pain management program to address these issues is reasonable and the best opportunity for more favorable outcome and should be beneficial in attempting to return the claimant to the workforce has

completed 9 sessions of physical therapy from 7/1/09-8/3/09 as well as 10 sessions of the chronic pain management program under the supervision of Dr. from dates of services 9/14/09-9/25/10. Ms. still complains of bilateral knee pain. She states the pain is anywhere from 6-8/10 on the VAS scale. She notes her pain is constant and has a pain quality of sharp, dull, stabbing, and shooting aches that radiate down both her legs. At her 11/24/09 office visit, she stated that she frequently trips and stumbles due to her pain.”

On February 17, 2010, M.D., a physician, evaluated the claimant. Impressions: Knee joint pain. Chronic pain syndrome. Gait Deficit. Prescriptions: Meloxicam 15mg, Lyrzia 75mg, and Norco 10/325 mg.

On February 19, 2010, the claimant underwent a FCE with Direct Medical Healthcare. Per the FCE the claimant is 5’9” and 240 pounds. The claimant tested in the Sedentary PDL.

On March 4, 2010, , M.D., an orthopedic surgeon, evaluated the claimant. Impression: Knee pain, chondromalacia, and patello-femoral syndrome.

On March 10, 2010, M.D., a physician, re-evaluated the claimant. Impressions: Knee joint pain. Prescriptions: Meloxicam 15mg and Lortab 10/500mg.

On March 19, 2010, Range of motion testing was performed on the claimant. Left knee: Flexion 63° and Extension 0°. Right knee: Flexion 70° and Extension 0°.

On April 20, 2010, D.O., a pain medicine physician, denied an additional 80 hours of chronic pain management program for bilateral knees. Rational: There is no indication of the improvements in the functional aspect of her rehabilitation. There is no indication of what her increased tolerabilities are in regards to walking, squatting, stooping, kneeling, and standing. There is no indication as to any significant decrease in medications.

On April 26, 2010, MRI of the right knee was performed, read by, M.D. Impression: There is a small joint effusion, otherwise normal.

On May 11, 2010, M.D., a pain management physician, denied additional 80 hours of chronic pain management program for bilateral knees. Rational: There is inadequate documentation of objective improvement with regards to this claimant’s condition that would justify an additional 80 hours of chronic pain management.

PATIENT CLINICAL HISTORY:

The claimant was employed as an xxx. Onxx/xx/xx, the claimant injured her bilateral knees when she slipped on a wet floor landing directly on her knees.

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

Upon independent review the reviewer finds that the previous adverse determination should be upheld. There is inadequate documentation of objective evidence of progressive improvement of the Claimant's physical abilities and response to the pain management program, which she has already had. There is also no documentation of a program to decrease her pain medication, and to return her to at most an over the counter pain control program. There is not a precise plan of the pain management program to address the Claimant's needs and the prospective expectations resultant from the additional 80 hours of a pain management program. Chronic pain programs (functional restoration programs)

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 exam 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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(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).

(13) At the conclusion and subsequently, neither re-enrollment in 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 (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. ([Keel, 1998](#)) ([Kool, 2005](#)) ([Buchner, 2006](#)) ([Kool, 2007](#))

As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids](#); [Functional restoration programs](#).

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)