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DATE OF REVIEW: 05/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management x 10 sessions

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

This case was reviewed by a Texas licensed MD, specializing in Preventive Medicine/Occupational Medicine. The physician advisor has the following additional qualifications, if applicable:

ABMS Preventive Medicine: Occupational Medicine

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Chronic Pain Management x 10 sessions	97799	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	First Report of Injury		9	11/21/2008	06/03/2009
2	Diagnostic Test	Upright MRI	1	12/11/2008	12/11/2008
3	Op Report	Surgery Center of	4	01/14/2009	01/14/2009
4	Office Visit Report	HealthCare System	11	02/27/2009	02/27/2009
5	FCE Report	Rehab	4	03/17/2009	03/17/2009
6	Impairment/Disability Rating Report	MD	3	04/08/2009	04/08/2009
7	PT Notes	HealthCare	40	11/24/2008	04/20/2009
8	Diagnostic Test		1	04/22/2009	04/22/2009
9	Office Visit Report	MD	13	12/18/2008	05/06/2009

10	Claim Dispute Notice	Group	11	12/08/2008	05/22/2009
11	Office Visit Report	DO	43	11/21/2008	05/27/2009
12	Claim File	Associates LC	5	04/22/2009	06/08/2009
13	Voluntary Request	TDI-DWC	5	04/27/2009	07/02/2009
14	FCE Report	Therapy & Diagnostics	3	09/15/2009	09/15/2009
15	Office Visit Report	MD	3	09/15/2009	09/15/2009
16	Psych Evaluation	LPC	7	01/19/2010	01/19/2010
17	FCE Report	Functional Testing	4	01/19/2010	01/19/2010
18	Initial Approval Letter	Comapany	14	12/08/2008	02/02/2010
19	Designated Doctor Report	MD	13	11/13/2009	02/03/2010
20	Office Visit Report	Pain & Recover Clinic	33	02/05/2009	02/18/2010
21	Initial Denial Letter	Company	7	02/23/2010	03/08/2010
22	Office Visit Report	MD	19	06/22/2009	03/12/2010
23	IRO Request	Pain & Recovery Clinic	13	04/19/2010	04/21/2010
24	Appeal Denial Letter	Pain & Recovery Clinic	2	03/03/2010	03/03/2010
25	Initial Request	Pain & Recovery Clinic	4	01/27/2010	03/04/2010
26	Archive	L.C.	9	01/04/2010	03/30/2010
27	Claim File	TDI-DWC	4	10/02/2009	10/23/2009
28	Archive	File	285	04/27/2010	04/27/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

285 pages of notes were reviewed. In summary, the claimant is a woman with an occupational incident date xx/xx/xx. The claimant reportedly had the onset of right knee pain when she tripped and fell . The claimant was seen initially at on xx/xx /xx with complaints of right knee pain after tripping on a piece of metal on the floor and landing on the right knee. X-rays are negative and the diagnosis was crushing injury to the right knee. The claimant was placed on modified duty and was started in physical therapy. MRI of the right knee was performed on 12/11/08 and this showed patellofemoral arthritis and tear of the posterior horn of the medial meniscus. The claimant was then referred to ortho and she was seen by Dr. on 12/18/08. It is noted that the claimant has had minimal improvement with conservative treatment. Surgery was recommended and right knee arthroscopy, chondroplasty, removal of loose body, and partial medial meniscectomy was performed by Dr. on 1/14/09. Post operatively the claimant had physical therapy at Nova. On 2/9/09, Dr. released the claimant to full duty without restrictions. On 2/27/09 the claimant was seen at with increased leg pain and swelling. She was instructed to go to the ER for an evaluation. In the ER an ultrasound was performed and there was no DVT. Physical therapy at continued. FCE was performed on 3/17/09 and this is reported to show light physical capability. On 4/8/09 the claimant was placed at MMI by Dr. with a 2% impairment rating. The claimant returned to see Dr. on 4/13/09 because of increased pain after returning to work. The claimant was placed on modified duty and additional therapy was recommended. Repeat MRI was performed on 4/22/09 and this showed an MCL sprain. The menisci were obscured by motion artifact. The claimant then came under the care of Dr. on 6/22/09 where she had complaints of swelling and pain. The claimant is reportedly not working and orthopedic consultation was recommended. The claimant was seen by Dr. on 9/15/09 where pain level was 8/10 over the anterior portion of the knee. Dr. recommended another surgery to that knee. A designated doctor evaluation by Dr. on 12/2/09 indicated the extent of injury was the question but the report was not very clear about this. A mental health evaluation on 1/19/10 indicated a chronic pain management program was recommended. FCE on 1/19/10 showed light PDL. Preauthorization review by Dr. on 2/2/10 recommended authorization for 10 days of a chronic pain management program. On 2/3/10 there is a letter of clarification from the designated doctor clearly delineating the extent of injury to not include the patellofemoral arthritis and chondromalacia. The claimant attended 10 sessions of a chronic pain management program in February 2010. Progress summary on 2/17/10 reported improvement with the first 9 days of treatment. BDI and BAI are decreased from 20 to 12 and 19 to 11 respectively. Preauthorization review performed by Dr. on 2/23/10. He did not recommend 10 additional sessions of CPM because of a lack of data on attitudes and beliefs about pain and disability as well as a lack of objective data on physical functioning. Reconsideration review of 10 additional sessions of CPM was performed by Dr. on 3/8/10 and she upheld the prior adverse determination citing inadequate evidence of significant progress and noting that the goal of achieving a heavy demand level was not a realistic goal given the claimant's present lifting ability. The claimant was seen by Dr. on 3/12/10 where it is

noted that additional chronic pain program was in the IRO process. It is noted that the claimant remained on the same medications as prior to initiating the CPM.

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

The claimant has already attended 10 sessions of a chronic pain management program for her right knee complaints. ODG guidelines specifically 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." Dr. indicated that although there was some decrease in BDI and BAI there was no clear evidence of improvement in any other areas. Dr. appeared to come to the same conclusion. Closer inspection of the medical records submitted does not show significant objective progress. Specifically there is no change in pain medication use as documented on the 1/4/10 and 3/12/10 office visits with Dr.. Both the type of medication and the amounts used were unchanged. Similarly, the notes documenting the exercise routine performed in the CPM showed essentially the same exercises being performed at each session. The only change from 2/5/10 to 2/18/10 was an increase in 1 set, from 3 to 4, for seated row and bicep exercise with no change in any other parameters. Therefore, the request for additional 10 sessions of Chronic Pain Management is not medically necessary.

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

Official Disability Guidelines

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 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.

(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](#).

- 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)

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 05/11/2010.