



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165
Ph 972-825-7231 Fax 975-775-8114

Notice of Independent Review Decision

DATE OF REVIEW: 9/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a 10 sessions of chronic pain management for the left knee (5 x wk 2 wks – 80 hours; 97799).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a 10 sessions of chronic pain management for the left knee (5 x wk 2 wks – 80 hours; 97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Spinal Rehab Center and Healthcare WC

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Spinal Rehab Center: CPMP Progress notes – staffing dates 7/8/10 & 7/29/10.

Records reviewed from Healthcare WC: Spinal Rehab Ctr CPMP Progress notes – staffing dates 7/1/10, Pre-auth request – 7/13/10, Psychological Diagnostic Interview and Testing report – 5/12/10, Initial Consult – 5/12/10; and Denial letter – 7/12/10.

We did not receive WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, the patient is a who was injured while working on. She slipped and fell landing initially on her knees. She apparently sustained primary injury to her left knee. She was treated with ice and ibuprofen and continued to work on the date of injury. On the following day, she was seen in an emergency room where she was given medications and imaging studies were made. She was subsequently referred to for treatment and received medications and physical therapy. At some point in her treatment, she also received a steroid injection which reportedly did not help.

She was referred to M.D., an orthopedist, who initially recommended more aggressive physical therapy. According to subsequent records, she had about three months of physical therapy. During her physical therapy sessions, however, her pain increased and her knees swelled. Dr. and a second orthopedist recommended total knee replacements, but Dr. indicated that this could not be done under Worker's Compensation and stated that there were medical problems that needed to be cleared prior to surgery. He then recommended that she undergo a chronic pain management program rather than have the recommended total knee replacements.

At some point, the patient had a Designated Doctor Evaluation and was placed at maximum medical improvement with 0% impairment.

On May 12, 2010, the patient was evaluated by M.D. to begin a chronic pain management program. Dr. noted that the patient's medical problems included diabetes mellitus, history of stroke, epilepsy, and possible coronary artery disease. Dr. indicated that the left knee was not swollen, but was diffusely tender. No crepitus was noted. Range of motion was from 0° to 95°. He diagnosed a left knee contusion and degenerative joint disease and recommended a chronic pain management program.

On May 12, 2010, the patient underwent a psychological evaluation by M.A., who noted that she had abnormal Beck depression and anxiety inventories as well as an interrupted sleep pattern. A chronic pain management program was recommended in order to allow the injured worker to avoid knee surgery.

Eighty hours of chronic pain management were approved at some point and the patient began the program in June. An interdisciplinary staff note dated July 1, 2010 indicated that The patient had missed participation in the chronic pain management in June due to a death

in the family, problems related to flooding of her apartment, and car damage. According to the available medical records that the patient resumed the therapy program in July. The last staffing note I have is dated July 29, 2010. This staffing note indicated that the patient had a pain level of 7, was no longer taking pain medications, had shown improvement in her BDI and ADI, had improved in her PDL, and had improved in her aerobic output goals.

Record review indicates that a request for a continuation of chronic pain management past the initial 80 hours was denied on record review by M.D. Dr. stated that therapy progress notes objectively documenting response were not provided, that there had been no improvement in BDI or BAI scores, and that the patient's compliance was poor. He also stated that updated goals of treatment were not provided. A reconsideration by, D.O. also recommended denial of the requested 80 hours of continued chronic pain management because "medical necessity, clinical utility, and anticipated potential benefits were not established."

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

This worker was injured during a work related accident on xx/xx/xx. Her primary injury was to her left knee. She was treated aggressively with medications and physical therapy and it was recommended by her treating physician and a second orthopedic opinion that she consider total knee replacement. Because of complicating medical problems, the surgeon who suggested that she was a candidate for total knee replacement recommended that she undergo chronic pain management in an attempt to possibly avoid knee replacement.

She began a program of chronic pain management in June, but because of personal issues including a death in the family, flooding of her apartment, and damage to her vehicle, she was not able to participate in the program in June. Records indicate that she resumed the program in early July and was making significant progress as documented in the last note of July 29, 2010. The note at that time indicated that her pain level had not changed and remained 7. The records seem to report that she is no longer taking Vicodin or narcotic pain medications for pain relief.

The record indicates that her BDI and ADI scores remained in the mild range, but improvement was noted in her emotional and psychological state. Her BDI score was improving. The record indicates that she was making progress on a weekly basis toward reaching her goal of lifting 25 pounds and a PDL level of medium. The record indicates that her aerobic output goals were increasing and being met. The report indicates that although she was initially "noncompliant" with her chronic pain management program, she is now compliant and expressing goals of increasing standing tolerance and strength in order to return to work. The record further indicates that she has a job to return to if she is able to be released with no standing restrictions.

Integrative summary reports are available in this medical record indicating treatment goals, compliance, and progress assessment with objective measures. Also, there is evidence of compliance and significant demonstrated efficacy as documented by subjective and objective

gains toward stated goals. Therefore, this individual meets the ODG Guideline requirements for medical necessity of ten additional sessions of chronic pain management for the left knee.

ODG 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). 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.

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)**