

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Aug/06/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

97799 Interdisciplinary Chronic Pain Management Program x10 Sessions; 80 Hours

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

MD, Board Certified Physical Medicine and Rehabilitation

**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**

Official Disability Guidelines

Operative report 08/23/02

Progress notes 08/25/02-06/28/11

Operative report dated 09/22/02

Offer Temporary Alternative Duty 01/28/10 and 03/05/10

Left knee MRI dated 03/18/10

Prior peer reviews dated 03/24/10, 04/21/10

Videonystagmography dated 05/14/10

RME dated 08/20/10

Range of Motion and Manual Muscle Test 10/07/10-03/08/11

Work Task Analysis Report 10/25/10

Operative report 01/11/11 and subsequent reports

Radiographic report PA and lateral views of chest dated 01/11/11

IRO review or 12 additional rehab sessions with 4 procedure units dated 05/09/11

Functional capacity evaluation dated 05/24/11

Behavioral Health Evaluation dated 05/26/11

Job Description, undated

Letter of medical necessity, undated

Collaborative report of Medical necessity for Interdisciplinary chronic pain management program dated 06/09/11

Utilization review request chronic pain management program x 10 sessions dated 06/16/11

Request for reconsideration for chronic pain management dated 06/21/11

Utilization review reconsideration chronic pain management program x 10 sessions dated 06/28/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was lifting a basket of clothes when she turned and felt pain in the left knee. The patient did not seek medical treatment until 01/26/10 because she thought it would get better. The patient is status post previous right knee arthroscopy in 2002. Left knee MRI dated 03/18/10 revealed tear of both menisci and a large joint effusion. Peer review dated 03/24/10 reports that given the passage of time between the alleged injury event and her presentation to a physician for evaluation, there is insufficient evidence to suggest a causal relationship between her ongoing knee problems and a traumatic event. A simple twisting motion on an extended knee is not consistent with the mechanism of injury required to tear a medial meniscus under normal circumstances.

Peer review dated 04/21/10 indicates that the meniscal tears and degenerative joint disease are pre-existing. Designated doctor evaluation dated 08/20/10 indicates that that the extent of the patient's compensable injury is medial and lateral meniscal tears. The patient underwent partial medial and lateral meniscectomy of the left knee on 01/11/11 followed by 12 sessions of physical therapy. Functional capacity evaluation dated 05/24/11 indicates that current PDL is sedentary and required PDL is medium. Behavioral health evaluation dated 05/26/11 indicates that HAM-D score is 21 indicating a severe level of depression and HAM-A score is 30 indicating a severe level of anxiety. Diagnoses are pain disorder associated with both psychological factors and a general medical condition, major depressive disorder and generalized anxiety disorder. Physical therapy was denied on IRO noting that the patient needed only a home exercise program.

Initial request for chronic pain management program was non-certified on 06/16/11 noting that it is unclear how the patient's doctor has attempted to address the psychological issues or why they were not initially addressed. The denial was upheld on appeal dated 06/28/11 noting that the functional capacity evaluation is compatible with full duty return to work at the patient's job and no work trial has been attempted. The treating orthopedist has recommended viscosupplementation which has significant potential to alter the pain complaints.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient has been diagnosed with major depressive disorder and generalized anxiety disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy to address severe levels of anxiety and depression. The patient's orthopedist has recommended viscosupplementation. Given the current clinical data, the requested 97799 Interdisciplinary Chronic Pain Management Program x10 Sessions; 80 Hours is not indicated as medically necessary.

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

ACOEM-AMERICA 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)