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Notice of Independent Review Decision

DATE OF REVIEW: 1/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a chronic pain management program five times per week for two weeks to the right knee. (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. The 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 agrees with the previous adverse determination regarding the prospective medical necessity of a chronic pain management program five times per week for two weeks to the right knee. (97799)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The injured employee sustained a work related injury xx/xx/xx when he fell and landed on his right knee. Initial x-rays were negative, but subsequent MRI of the injured right knee was reported to show a diagonal fracture of the medial tibial plateau with minimal impaction, a small joint effusion, a partial tear or sympathetic inflammation within the medial collateral ligament, mild finding of abnormal patellar mechanic and chondromalacia patella. Initial treatment included physical therapy and medications. Dr. at Medical Center referred the injured worker to Dr. for evaluation and treatment.

The injured worker was seen by Dr. on June 3, 2009 for orthopedic consultation. Dr. diagnosed a medial tibial plateau fracture of the right knee with associated medial collateral ligament sprain. He noted that the posterior right thigh pain might represent a subacute hamstring strain or possibly referred radicular-type pain from the lumbosacral spine. Dr. recommended non weight bearing on the injured lower extremity, using crutches and a hinged brace. He recommended MRI of the thigh and further evaluation of the lumbosacral spine might be required to ensure that these symptoms were not related to radiculopathy. The injured worker was released to light duty work.

On June 18, 2009 Dr. noted that the symptoms were not explained by the medial tibial plateau fracture and he was concerned that the symptoms might be radicular in nature. On July 29, 2009 Dr. noted quadriceps atrophy on the right, tenderness along the medial joint line of the knee, and positive patellar grind. There was no tenderness directly over the medial tibial plateau. Knee x-rays showed no evidence of fracture over the [medial tibial plateau] (transcribed as metatarsophalangeal). X-rays of the lumbosacral spine were reported to show decreased disk space at the L4-L5 level. Dr. commented that the patient's knee films did not demonstrate the previous medial tibial plateau fracture, which was clinically nontender, but "he is having some patellofemoral-related symptoms in part due to his lower back issue and some quadriceps weakness". Dr. proposed gradually weaning from the crutches, working on a physical therapy program for the knee as long as it does not exacerbate the lower back symptoms.

On October 9, 2009 Dr. noted that the injured worker felt that the knee injection provided some relief but he was still having difficulty weight-bearing and was using crutches. He continued to have radicular-type symptoms and posterior thigh pain. Straight leg raising produced pain posteriorly in the thigh. Dr. went on to say "I would like to obtain a follow up MRI scan of his knee given his persistent complaints. He had posterior thigh pain with a negative MRI scan for hamstring injury. This suggests referred pain from his lower back.... I would like to check him back after obtaining a follow up MRI scan of his knee."

On November 25, 2009 the injured worker was seen for psychological evaluation to determine the appropriateness of a work hardening program. The program began 3/19/2010, continuing for 2 weeks.

On March 24, 2010 a PPE documented lifting overall in the Light category. Pain and

tenderness were reported during several activities, including walking, sitting, standing, reaching, stooping, crouching, kneeling, crawling, balance, squatting, and overhead reaching. For each of these activities, the examiner reported that "this is not a safe activity or function for the patient to be performing right now and should be considered when determining if the patient can safely return to work (without restrictions)." The patient was found to have joint crepitus in or around the area of complaint.

The program was resumed in May. On the work hardening program progress note May 21, 2010 the decrease in endurance and performance was attributed to the two-month gap in treatment. Endurance improved by the fourth week of the program, as documented May 28, 2010.

On October 4, 2010 the injured worker was seen at the request of Dr. for psychological evaluation to determine the appropriateness of a chronic pain management program. The injured worker reported physical therapy was not beneficial, E-stim and a TENS unit were helpful. There was some benefit from exercise therapy and temporary relief from injections. Work hardening was somewhat helpful. Physical therapy was helpful. The evaluator recommended that the patient enter into an Interdisciplinary Chronic Pain Management Program. Instead of entering a chronic pain management program the injured worker continued the work hardening program for three more weeks, completing the seventh week November 11, 2010.

According to the work hardening program progress note November 4, 2010, the patient attained heavy work level with dynamic lifts. On the weekly status summary November 11, 2010 the patient was functioning in the heavy work level, lifting 70 pounds occasionally. He was working on resume building, interviewing skills, work appearance, job applications, identifying current or transferable job skills, improving computer skills, Internet training, improving conducting job searches, how to improve functioning and work environments.

On November 8, 2010 a PPE documented lifting overall in the Light to Medium category. Pain and tenderness were reported during several activities, including walking, sitting, standing, reaching, stooping, crouching, kneeling, crawling, balance, squatting, and overhead reaching. For each of these activities, the examiner reported that "this is not a safe activity or function for the patient to be performing right now and should be considered when determining if the patient can safely return to work (without restrictions)." The patient was found to have joint crepitus in or around the area of complaint.

On November 15, 2010 a request was submitted for precertification of an outpatient chronic pain management program.

The requested program was not authorized November 19, 2010. Request for an appeal was submitted on the same date.

DIAGNOSTIC STUDIES

- 2009/05/13 MRI of the right knee: diagonal fracture of the medial tibial plateau with minimal impaction. Partial tear or sympathetic inflammation within the medial collateral ligament, mild finding of abnormal patellar mechanic and chondromalacia patella, small joint effusion.
- 2009/06/04 MRI of the right thigh: Multipartite Patella. No fracture or stress reaction, hamstrings tendons and muscles are intact, myotendinous junctions are preserved, neurovascular bundles are intact.
- 2010/04/08 MRI of the lumbar spine: disc desiccation L4-L5. findings consistent with anterior and posterior annular tear. Small focal protrusion of the disc along the posterior disc margin near the midline and probably slightly to the left of the midline, producing a mild anterior extradural defect on the thecal sac and mildly narrows the developmentally small central spinal canal.
- 2009/04/27 x-ray of the right knee: small joint effusion, tripartite patella.
- Other x-rays were performed by Dr, as described in his clinical notes.

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

According to the ODG Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updated 12/15/10) Criteria for the general use of multidisciplinary pain management programs, the following are listed:

(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) (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.

On October 9, 2009 Dr. recommended a follow up MRI scan of the knee “given his persistent complaints....I would like to check him back after obtaining a follow up MRI scan of his knee.” No records were submitted regarding whether the recommended follow up MRI was done or whether the recommended follow up appointment with Dr. took place.

According to the physical performance evaluations of 3/24/2010 and 11/8/2010, the listed activities limited by pain and tenderness appeared to be the same, verbatim in each report, implying that the injured worker would not be safe at work without restrictions:

The PPE dated March 24, 2010 documented lifting in the Light category, with pain and tenderness while walking, sitting, standing, reaching, stooping, crouching, kneeling, crawling, balance, squatting, and overhead reaching. For each of these activities, the

examiner reported that "this is not a safe activity or function for the patient to be performing right now and should be considered when determining if the patient can safely return to work (without restrictions)."

On November 8, 2010 a PPE documented lifting overall in the Light to Medium category, with pain and tenderness while walking, sitting, standing, reaching, stooping, crouching, kneeling, crawling, balance, squatting, and overhead reaching. For each of these activities, the examiner reported that "this is not a safe activity or function for the patient to be performing right now and should be considered when determining if the patient can safely return to work (without restrictions)."

The follow up MRI and follow up clinic visit with Dr. (if done) would have direct bearing on assessment of the "presence or absence of other options likely to result in a clinical improvement". If the repeat MRI and the follow up orthopedic visit were *requested and not authorized* then the above-enumerated ODG criteria would have been met, including the criterion that "there is an absence of other options likely to result in significant clinical improvement". Because all of the options have not been satisfied, the requested treatment is not medically necessary at this time.

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)**