Notice of Independent Review Decision

DATE OF REVIEW: **12/31/10**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic Pain Management program x 10 sessions (5 times per week for 2 weeks).

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

The reviewer is a board certified MD in Occupational Medicine licensed to practice in Texas.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who was working at a xxxx and claims that she tripped and fell landing on both knees on xx/xx/xx. She was seen by Dr. due to bilateral knee pain. An MRI was performed on 7/20/07 and showed a tear of left medial meniscus and right oblique tear of medial meniscus. Dr. performed a bilateral partial/medial and lateral meniscetomy on 9/20/07 and 12/3/07. On 10/22/07, Dr. from recommended patient's participation in 6 individual psychotherapy sessions. Due to lack of improvement post surgery to the right knee, a repeat MRI was ordered on 4/25/08 which showed surgical changes as well as a tear of the anterior horn of medial meniscus with a cartilaginous ulcer of the medial femoral condyle. The patient had a second surgery to the right knee on 6/22/09 performed by Dr. (mosaicplasty, chondroplasty, partial medial menisectomy and synovectomy). The extent of injury was determined by Dr. and includes the right recurrent medial meniscus tear and post operative repair on the left knee. She was evaluated by therapist group on 6/4/10 and 8/2/10 who recommended the examinee participate in individual psychotherapy sessions to address high levels of stress and depressive symptoms and in a chronic pain management program.

The patient's right knee condition had not improved after the surgery and a diagnosis of reflex sympathetic dystrophy was suggested by Dr..

The examinee was placed at statutory MMI on 7/28/09 and was given an 8% IR.

Dr. continued to see the patient on 2/12/10, 3/12/10, 4/2/10, 5/14/10, 6/14/10, 7/21/10, 8/18/10, 9/15/10 and 10/13/10. He recommended a referral to a pain management specialist. An FCE was performed on 9/24/10, concluding the examinee can handle a light to medium PDL; however, she has not returned to work.

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

The patient meets ODG criteria to participate in a chronic management program as follows:

Delayed recovery: patient received full diagnostics, injections, physical therapy, 3 knee surgeries, individual psychotherapy with work hardening program and medications without improvement. The patient is dependent on ongoing healthcare provider treatments.

There is no personality disorder. Her psychological issues, pain disorder and adjustment disorder are apparently related to her medical condition. The patient is not on narcotic medication and is a nonsmoker.

It is noted that there is conflicting evidence that patients on a chronic pain

management program return to work beyond 24 months. The patient's FCE showed she can return at a light to medium PDL; however, she has not returned to work. This is a negative predictor; however, this in itself should not preclude the patient from being admitted to a chronic pain management program.

A chronic pain management program is recommended for 2 weeks (10 sessions) of participation with reevaluation after this period to assess outcomes, compliance and progress.

REFERENCES

ODG Guidelines, Chapter on Chronic Pain

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)**