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Notice of Independent Review Decision

DATE OF REVIEW: December 20, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program – 10 sessions

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

Certified by American Board of Psychiatry and Neurology
Licensed by Texas State Board of Medical Examiners

REVIEW OUTCOME

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

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury xx/xx/xx, when he was performing his job responsibilities and slipped and fell on his knees.

2009: M.D., evaluated the patient for left elbow and left knee discomfort. On examination there was medial and lateral knee joint tenderness. X-rays of elbow and knee were unremarkable. The patient was diagnosed with left knee contusion and left elbow sprain, prescribed Motrin and biofreeze and was given a 6-inch ACE wrap for his knee. He was advised on no lifting more than 20lb. Subsequently the patient was treated with three sessions of physical therapy (PT) consisting of interferential current, ultrasound and therapeutic exercises.

A magnetic resonance imaging (MRI) of the left knee was obtained which revealed medial and lateral meniscus tears and three-compartment hypertrophic change.

2010: The patient was treated with three series of Supartz injections but continued to be symptomatic. He was then referred to an orthopedist M.D., who performed arthroscopic partial medial and lateral meniscectomy, chondroplasty with microdrilling, synovectomy and lateral release on March 25, 2010. Postoperatively the patient was treated with 18 sessions of rehabilitative PT consisting of cold packs and interferential current

A repeat MRI was obtained for continued pain. This showed: (1) Osteoarthritic changes within the medial and lateral compartment of the knee joint with joint space narrowing and marginal spurring. (2) Prominent longitudinal tear within the medial posterior horn of the medial and lateral menisci. (3) Small joint effusion. (4) Subchondral erosion within the anterior nonweightbearing surface of the lateral femoral condyle measuring 6.3 mm in diameter. (5) Cystic structure overlying the patellar tendon measuring 1.33 cm transversely x 1.48 cm in craniocaudal diameter. (6) Marked tendinosis of the patellar tendon without tear. Prepatellar bursitis. (7) Mild edema within the subcutaneous soft tissues, lateral compartment of the knee joint presumably entry port for prior arthroscopic surgery.

On follow-up, Dr. noted the patient was using a cane for ambulation. He reviewed the MRI and referred him to M.D., for a second opinion.

Dr. noted locking and swelling of the knee. The patient walked with a limp. There was tenderness along the joint line with pain on McMurray's maneuver medially. He administered a cortisone injection into the knee and recommended repeat arthroscopy if there was no relief with injection.

D.C., treated the patient with therapy and gave prescription for ice packs, Biofreeze, knee sleeve support, an EMS unit, Biofreeze, and cane.

In a psychological evaluation, the patient was diagnosed with chronic pain disorder associated with both psychological factors and a general medical condition. The evaluator recommended six sessions of individual therapy which the patient underwent through September 2010.

X-rays of the lumbar spine revealed L3 vertebral body compression deformity of indeterminate age; L4-L5 grade I anterolisthesis and loss of disc height; and possible muscle spasm. X-rays of the knee was unremarkable.

In a functional capacity evaluation (FCE), the patient did not meet the job requirements. The evaluator recommended participating in chronic pain management program (CPMP).

Dr. opined that the patient presented with internal derangement and mechanical symptoms. The MRI revealed prominent longitudinal tear within the posterior horn of the medial and lateral meniscus. He scheduled the patient for left knee arthroscopy to relieve the mechanical symptoms as conservative measure had failed.

On October 13, 2010, D.O., denied the request for CPMP with the following rationale: *“There was no postoperative imaging of the left knee with and without contrast. There is no operative report provided from prior surgery – which was approved to address the meniscus authority. A with extensive degenerative changes in the knee. Unclear as to the benefit of the arthroscope. Claimant has seen multiple physicians and recently was referred for IT at. Unable to establish medical necessity for another surgery under injury claim”*. It was noted that on September 24, 2010, the patient was referred to IRO with regards to surgery request

On October 26, 2010, a request for reconsideration was placed by D.C. with the following explanation: Dr. denied the program due to the patient not having surgery despite the requests for surgery being denied twice. Tertiary chronic interdisciplinary pain program is considered as standard line of treatment. The patient meets all the criteria for general use of multidisciplinary pain management and hence the appeal for CPMP five time a week for two week was needed.

On November 3, 2010, Ph.D., denied the appeal with following rationale: *“It cannot be established that all care has been exhausted and it could not be reasonable to consider the patient at appropriate candidate for CPMP as result. Dr. stated that he was unaware the request for surgery was actually submitted to IRO but i gave him date it was submitted according to the information available. He agreed that time that the request for CPMP is not reasonable until all the options of the treatment have exhausted and he accepted that denial for CPMP. Based on the available informations the request does not appear to reasonable and necessary, per evidence-based guidelines.”*

On November 10, 2010, Dr, noted continued complaints pain. The IRO decision was still pending. He recommended continuing Motrin and waiting for the IRO decision to schedule the surgery.

On December 13, 2010, Ph.D., in a medical dispute resolution stated after reviewing the rationale given by Dr. and; the program was denied twice due to the patient not having the recommended surgery. The surgery request has been denied by IRO and was no longer pending. As all lower levels of care has been exhausted, this program was reasonable and necessary to address remaining deficits. The patient met the criteria for the general use of multidisciplinary pain management program according to ODG.

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

The patient has been referred to CPMP but has been denied twice. Each time, the reviewer's rationale for denial was related to one factor: a request for surgical intervention was pending. The reviewer's opinion was that as long as surgery was still an option, the ODG requirement that all other options have been exhausted was not met. However, more recent information on the case apparently reveals that the surgical option has been denied and there are no plans to proceed with surgery. Thus, all alternative options have now been exhausted and this final ODG requirement is now met. Other ODG requirements for CPMP have been reviewed and have been met. Thus, the request for 10 sessions of CPMP is now consistent with ODG guidelines and thus medically necessary and should be approved.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**