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Notice of Independent Review Decision

DATE OF REVIEW: December 30, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of chronic pain management program

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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]:

The patient is a male who injured his left knee on xx/xx/xx, while he was walking from the second floor into the stairs and fell.

Initially D.O., treated the patient with physical therapy (PT) and medications for the diagnoses of unspecified internal derangement of left knee, synovitis and tenosynovitis and knee sprain.

Magnetic resonance imaging (MRI) of the left knee revealed: Acute, partial-thickness tear of the distal anterior cruciate ligament (ACL); the tear involved

approximately 50% of posterolateral fiber bundles at the tibial attachment; acute, partial-thickness tear of the medial collateral ligament (MCL), grade II in appearance; small knee joint effusion; and small acute bone contusion along the posterolateral, nonweightbearing surface of the lateral femoral condyle. Electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities was essentially unremarkable.

On October 29, 2009, M.D., performed left knee ACL reconstruction, PCL augmentation, partial medial and lateral meniscectomy, three compartment synovectomy, abrasion chondroplasty of medial femoral condyle and removal of adhesions. Postoperatively, he weaned the patient off crutches and started PT.

On March 4, 2010, Dr. performed left knee arthroscopy with synovectomy. Postoperatively, the patient did well, but had 2/5 quad strength.

From May through June 2010, the patient attended 20 sessions of work hardening program (WHP). He plateaued in his physical activities and continued to complain of knee pain, an increase in depression and anxiety due to the elevated pain. In a functional capacity evaluation (FCE), he qualified at a heavy physical demand level (PDL) similar to his job required PDL. He was recommended individual psychotherapy sessions.

In a designated doctor evaluation (DDE) M.D., assessed clinical maximum medical improvement (MMI) as of July 14, 2010, and assigned 4% whole person impairment (WPI) rating. Based on the FCE, Dr. stated the patient was capable of work without restrictions.

In August, M.D., an orthopedic surgeon, saw the patient for pain on the medial aspect of the left knee with locking and pain under the patella. He was unable to stand or fully weight bear on his left leg. Examination showed 0 to 120 degrees of ROM, small effusion, pain over pes bursa, medial and lateral joint line pain, and audible crepitus with pain. McMurray's was positive. Dr. suspected a new meniscal tear and ordered MRI, PT and HEP.

MRI of the left knee revealed long ACL graft anchored in its proximal portion with a transverse screw in the distal femoral diaphysis, thinned graft in its central portion although intact with good fibrointegrity, tiny joint effusion, postoperative debris in Hoffa's fat pad, chondral thinning of the medial femoral condyle anteriorly and patellar spurring.

M.D., started the patient on Celexa for depression secondary to chronic left knee pain.

In September, the patient attended six sessions of individual psychotherapy. Upon completion, the patient underwent psychological evaluation and was diagnosed with chronic pain syndrome and depression/anxiety. He was recommended interdisciplinary chronic pain management program (CPMP).

On October 4, 2010, the patient underwent physical performance evaluation (PPE) which indicated signs of decreased functionality due to left lower extremity injury. He qualified at a medium PDL. Per evaluator, he had exhausted all lower level modalities but was still unable to effectively deal with

his chronic pain. A full psychological evaluation and 20 sessions of CPMP were recommended.

On October 8, 2010, the request for 10 sessions of CPMP was denied by M.D., with the following rationale:

"The case presents somewhat contradictory findings as follows: (1) The claimant states he has depression/anxiety, however Beck scores are mild (and these were apparently pre-work hardening). (2) He has had adequate postoperative rehabilitation including 20 sessions work hardening. As there has been no subsequent re-injury or surgery, a repetition of this level program is not appropriate per ODG and patient being placed at MMI on July 14, 2010, appears appropriate and there was no clear reason to deteriorate from that point to now. (3) The September 20, 2010, postoperative knee MRI appears benign for a residual pain generator; therefore, there is no clear physical component to the case per ODG. (4). Page 2 of May 13, 2010, psyche exam states his "support system is poor", however, same day BHI-2 states it is good. Finally, it also appears the last psych evaluation was on May 13, 2010, which was prior to the work hardening which is structured to address such and his current status is unknown. Given these Items, I do not feel criteria have been met for CPM and request is recommended for non-certification at this time."

On November 3, 2010, Dr. appealed as follows: *"Despite individual counseling, the patient continued to experience increased symptoms of both depression and anxiety (BDI of 46 and BAI of 43 post IC sessions). The patient was given a script for Celexa 20 mg to assist with his depression during the IC sessions and was recommended for a more intense environment that WH or IC can provide that incorporates both physical and intense psychological treatment. Work hardening provides very limited psychotherapy with weekly group sessions only. Initially, this was an appropriate course of treatment given low levels of depression and anxiety on baseline psychological assessment. However; as the patient increased his physical functioning, pain complaints initiated increased psychological symptoms requiring additional counseling support. Although the patient was placed at MMI, he was sent to Dr. for a second opinion that recommends additional evaluation before placing the patient at MMI. The patient continues to have complaints of pain on the medial aspect of his knee and under his patella. His knee locks up and he has difficulty standing and fully weightbearing on his left leg, with notable decreased ROM. Recent MRI shows postoperative debris in Hoffa's fat pad and chondral thinning of the medial femoral condyle anteriorly, and patellar spurring. In regards to his support system, the discrepancy appears with clinical assessment and patient's self report. Individual counseling has assisted in increasing communication with his girlfriend of 10 years as an asset to his recovery and he has asked for temporary support from his father-in-law. Although the initial psychological evaluation was performed in May 2010, he has been actively seeking counseling services with our facility within WHP and individual counseling sessions. The continuity of care has initiated a clinician/patient relationship with consistent evaluation of his psychological state. The goals will include improved strength and stability of left knee, increased endurance and strength to meet PDL levels for return to work, increase ROM of his knee, and promote proper body mechanics and lifting safety to prevent re-injury or exacerbation of pain complaints. CPMP will also incorporate daily psychotherapy to better control his level of subjective pain and distress, increase constructive goal setting, and maximize his ability to return to a*

more productive lifestyle.”

On November 11, 2010, an appeal for 10 sessions of CPMP was denied with the following rationale: *“There was no documented evidence that the current program has "proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the healthcare system) for patients with conditions that have resulted in "Delayed recovery" per ODG for Pain regarding CPMP. In this case, the patient has undergone prior work hardening and individual psychotherapy with progressive deterioration of psychometric scores and improved functional abilities. Teleconference with clinical designee, stated that the depression was aggravated by loss of his job. As such, additional psychotherapy intervention within the context of CPMP is not likely to be efficacious. With Medium to Heavy capabilities the patient is capable of returning to the workforce in some capacity. Page 2 of May 13, 2010, psyche exam states his "support system is poor", however, same day BHI-2 states it is good. Therefore, inclusion criteria for the currently requested 10 sessions of CPMP have not been met and non-certification is recommended.”*

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

PATIENT HAS COMPLETED A COMPLETE COURSE OF WORK HARDENING, THERAPY, INDIVIDUAL COUNSELING AND ANOTHER COMPREHENSIVE PROGRAM, WHICH INCORPORATES THOSE ALREADY PERFORMED IS NOT WARRANTED OR RECOMMENDED BY ODG. DESPITE ALL THESE MODALITIES THERE HAS BEEN PROGRESSIVE DETERIORATION OF PSYCHOMETRIC SCORES, PART OF THE DEPRESSION IS SITUATIONAL, LOSS OF JOB, AS DOCUMENTED AND ADDITIONAL PSYCHOTHERAPY IS NOT LIKELY TO BE OF BENEFIT.

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

IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**