AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: January 4, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic PMP 10 sessions

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

This physician is Board Certified Physical Medicine and Rehabilitation Physician with 14 years of experience.

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

On August 6, 1998, the claimant underwent surgical intervention of the right knee as performed by M.D. Procedures: Arthroscopy of the right knee with debridement of the medial femoral condyle.

On February 25, 2002, the claimant was evaluated by, M.D. He did well until 2-3 weeks ago. Examination: Reveals no significant effusion. There is some swelling medially. There is crepitus in the knee with flexion and extension. Dr. performed the first Synvisc injection without difficulty.

On March 4, 2002, M.D. performed the second Synvisc injection into the right knee.

On March 11, 2002, M.D. performed the third Synvisc injection into the right knee.

On October 21, 2002, the claimant was re-evaluated by M.D. He did fairly well following his Synvisc injections. He had continued discomfort in his knee. X-rays show rather significant narrowing of the medial compartment with some spurring off the superior end of the patella. Examination: Reveals a varus deformity of the knee. He has patellofemoral and tibiofemoral crepitus with motion of the knee. He has ligamentous instability of the knee. He has a negative McMurray and negative Steinmann exam. He has trace effusion. He has tenderness along the medical joint line. Medications: Started him on Bextra 10mg a day.

On November 18, 2002, M.D. performed the first Synvisc injection into the right knee. (Second Series)

On November 25, 2002, M.D. performed the second Synvisc injection into the right knee. (Second Series)

On December 2, 2002, M.D. performed the third Synvisc injection into the right knee. His knee is feeling a little better following the injections. (Second Series)

On October 3, 2003, claimant was re-evaluated by, M.D. His knee has done quite well following the injections until about 2-3 weeks ago. His degenerative joint disease has had a flare-up. His knee was injected with Lidocaine and a steroid. Examination: No significant swelling or effusion. He has crepitus with motion of the knee. Vitals: Height 6 feet and weight 210 pounds.

On October 23, 2003, M.D. performed the first Synvisc injection into the right knee. The cortisone shot lasted about 1 week. (Third Series)

On October 30, 2003, M.D. performed the second Synvisc injection into the right knee. He has continued discomfort in the right knee. (Third Series)

On November 6, 2003, , M.D. performed the third Synvisc injection into the right knee. His knee is improving. (Third Series)

On June 7, 2004, He reaggravated his knee yesterday when he was trying to help a friend take his boat out of the water. He has trace effusion and a fairly large medial tibial osteophyte. There is no instability of the knee.

On June 9, 2004, , M.D. performed the first Synvisc injection into the right knee. There is a slight increase in swelling. (Fourth Series)

On June 23, 2004, M.D. performed the third Synvisc injection into the right knee. There is some improvement, but still there is discomfort. (Fourth Series)

On January 14, 2005, the claimant was re-evaluated by, M.D. His injections did not help to any significant degree. He has not done well with oral anti-inflammatory medications. Examination: Knee reveals a varus deformity with patellofemoral and tibiofemoral crepitus. There is no laxity of the knee.

On July 18, 2005, , M.D. performed an arthroscopy of the right knee with a medial compartment arthroplasty using uni-spacer implant.

On July 29, 2005, the claimant was re-evaluated by M.D. He still has some swelling and soreness in the knee but over all is getting along fairly well. He is ready for physical therapy.

On August 4, 2005, the claimant began post-operative physical therapy of the right knee, 3 times per week for 4 to 6 weeks.

On August 26, 2005, a progress re-evaluation was performed. His reports decreasing pain and using is cane less.

On September 9, 2005, a progress re-evaluation was performed by M.D. Examination: Antalgic gait on the right. Examination of the knee reveals a trace effusion. There is good stability of the knee.

September 27, 2005, a progress re-evaluation was performed. He reports less pain and that enables his to walk better and bend his knee better.

On October 13, 2005, the claimant was discharged from physical therapy of the right knee.

On January 4, 2006, the claimant was re-evaluated by, M.D. His knee is doing well overall. He is able to return to work with permanent restrictions. Examination: Reveals no swelling or effusion. ROM is 0-120 degrees. There is good tracking of the component and he has a good valgus configuration of the knee. Medications: He is started on Mobic 7.5 mg.

On September 14, 2009, the claimant was re-evaluated by, M.D. He has had increasing pain in the knee, he was taken off all medications and since then his

symptoms significantly increased. Has gait is antalgic on the right. He has no laxity of the knee. X-rays show the uni-spacer remains in good position. He has tricompartmental arthritis in the knee.

On November 1, 2010, L.P.C. performed a psychological evaluation. An Interdisciplinary Chronic Pain Management program was recommended to better control his level of subjective distress and pain behavior, increase constructive goal-setting, and maximize his ability to return to a more productive lifestyle. His pain continues well beyond expected tissue healing time.

On November 1, 2010, the claimant participated in a Physical Performance Evaluation. He is currently retired. He is currently at a. He is a good candidate for chronic pain management.

On November 17, 2010, M.D., a physical medicine and rehabilitation physician performed a utilization review on the claimant. Rationale for denial: The length of time the claimant is removed from the date of injury would be considered to be a negative predictor of a positive response to such an extensive program. Therefore it is not certified.

On December 6, 2010, M.D., a family practice physician, performed a utilization review on the claimant. Rationale for denial: The injury is now over 12 years old. FCE in 2010 showed submaximal effort. Claimant is 'disabled' and is not working. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to the right knee when he was walking upstairs and twisted his right knee.

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

The previous decisions are upheld. The ODG Pain Chapter 8 refers to negative predictors of success. In this case, there are several negative predictors for a positive response from a chronic pain management program, which include: the length of time from the injury date of x/xx/xx and the discharge from therapy on 10/05, a release with permanent restrictions in January of '06, lack of medical follow up (not until 9/09 then again on 10/10) and "retired status". Therefore, based on the ODG the previous decisions are upheld.

Per the ODG:

Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:
(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.
(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) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (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. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.
(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.
(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a "stepping stone" after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.
(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.
(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.
Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.

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)**