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Notice of Independent Review Decision

DATE OF REVIEW: March 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799 CPCA 80 hours of chronic pain management.

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

Clinical Psychologist; Member AAPM

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** 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 sustained a work related injury on xx/xx/xx, while working as an xx. He was climbing out of an attic on stairs and twisted his left knee.

On December 27, 2010, a functional capacity evaluation (FCE) was performed on the patient. It was noted that the patient had undergone various treatments including physical therapy (PT), surgery for meniscus and injections. Currently, the patient complained of left knee popping, locking up, with pain and stiffness in

the back of the knee when extended. During the FCE testing, the patient demonstrated fair endurance and moderate pain behaviors. He appeared to put forth maximal effort and fair body mechanics. The patient demonstrated functioning in the medium work level while his job was classified in the very heavy category. It was felt that the patient would benefit from an interdisciplinary rehabilitation program by addressing issues related to chronic pain by improving functional level and by learning coping and pain management skills.

On December 29, 2010, the patient underwent a behavioral health assessment to consider appropriateness of an interdisciplinary chronic pain program. Treatment history was reported to include medications, PT, home exercise program (HEP), multiple Synvisc injections and two surgeries to the knees. The patient ambulated slowly with an antalgic gait and he reported severe functional restrictions in many activities due to pain. He also reported difficulties in walking extended periods, climbing stairs, stooping or standing for long periods of time. He described his mood as depressed, admitted to sleep and appetite disturbance, fatigue and decreased libido. He also reported feeling discouraged, worried and nervous. The diagnostic impressions were pain disorder with psychological factors and medical condition and chronic pain syndrome secondary to left knee pain. The results were suggestive of adjustment difficulties which were likely to include significant depression and anxiety, substantial fear of re-injury and self-limiting pain avoidance behavior. The evaluator stated the patient was an appropriate candidate for interdisciplinary rehabilitation focused on functional restoration. The treatment was to address pain related emotional distress and pain behaviors with physical rehabilitation efforts.

D.O., evaluated the patient for left knee pain primarily in the medial and posterior component, difficulty with extension and pain score of 4 to 5/10. History was significant for left inguinal hernia repair and left knee arthroscopy x2. Examination of the spine revealed tenderness in the lumbar spine and paraspinous regions and pain increased with range of motion (ROM). Examination of the left knee showed previous surgery, full extension and near full flexion, palpable tenderness with possible Baker's cyst posteriorly and tenderness in the medial aspect of the knee. Dr. prescribed naproxen 500 mg and recommended initiating an interdisciplinary rehab program.

On January 13, 2011, a pre-authorization request was placed for 80 hours of chronic pain management treatment.

From February 7 through February 11, 2011, the patient attended five therapeutic sessions for the left knee. Each session lasted 8 hours.

On February 17, 2011, the request for 80 hours of chronic pain management to the left knee was non-authorized by Ph.D. Rationale: *"I discussed this case and requested procedure with. The clinical indication and necessity of this procedure could not be established. There are no acute medical problems, other clinical limitations, or evidence of a revised treatment plan for addressing any unusual pain rehabilitation problems which would justify extending this patient's pain program beyond the usual and customary standard of care. At this point, the patient should be able to continue the rehabilitation program and application of pain management skills independently, without regular professional*

supervision if the patient is presently assessed as not capable of this; inadequate Influence of the patient's behavior must be inferred. Current medication is limited to naproxen; the hydrocodone has already been successfully weaned. There is no Indication that the program should be extended "because of depression and anxiety scores. These are actually not documented, and the instruments used to infer this (without actual clinical assessment and opinion) are not sensitive and specific for this type of presentation. At this point, the projected need to assist the patient In achieving a PDL or "function^ capacity" necessary for a particular job or type of employment is not reasonable and adequate as an "Individualized care plan [with] specific outcomes, which would make extension of a full time chronic pain management program both reasonable and necessary; and there is no explanation as to "why improvements cannot be achieved without an extension." The patient has achieved only half the maximum lifting performance which would be necessary to return to his former Job. Achieving this within a pain program, is not likely to be accomplished and may take considerable time. There is no reason to believe that this one objective cannot be accomplished over time with other means, and it does not rationalize a full-time pain rehabilitation program. I am not able to establish a basis that continuing this treatment is both reasonable and necessary at this time. Non-approval is recommended."

On February 18, 2011, a formal request for reconsideration of denial of pain management treatment was documented. It was noted that the patient would be completing 160 hours of pain management treatment. Rationale: *"To date, his participation and compliance have been good. Functionally, the patient has improved and now managing 65 lbs on his Floor to Waist lift(s), Waist to Shoulder lift(s), Shoulder to Overhead lift(s), and his Carry(s). This data represents a 160% increase in his functional strength tasks. His cardiovascular tolerance is currently at 40 minutes with an overall cardiovascular goal of 60 minutes. The patient reports his average pain level this past week has been a 3/10 to a 4/10 on average, with periodic flare-ups that have elevated to 6/10 to 7/10. The patient has entered the program with high depression scale scores and moderate anxiety scores. He has been utilizing his individual and group counseling to his benefit. He also experiences significant support through the therapeutic milieu of the treatment program. The score on his Hamilton Depression Scale has begun to moderate. His medication has been addressed while in treatment. The patient was taking hydrocodone 7.5 mg, two each day at the onset of treatment. His hydrocodone has been discontinued and he is currently prescribed naproxen. The patient has work to return to; however, he needs to be in the very heavy physical demand level (PDL). He has worked hard and consistently while in treatment. He has been working on functional restoration as well as job simulation tasks. He has utilized his individual and group counseling to his benefit and his depression scale score is moderating, his anxiety has decreased, and he has discontinued his narcotic medication. Given the medication reduction, the notable depression and anxiety scores, and his very heavy PDL, the treatment team believes the patient meets the criteria to exceed 20 days of pain management treatment."*

On February 25, 2011, the reconsideration request for 80 hours of chronic pain management was non-authorized by Ph.D. Rationale: *"The program request is beyond recognized Standards and Guidelines of ODG. Guidelines also note that effective outcomes (for chronic pain programs) can be accomplished in less than 20 days and rarely more than 20 days are needed. ODG requires that "Longer*

durations require Individualized care plans explaining why Improvements cannot be achieved without an extension". After a standard program is completed, patients should be encouraged to function more independently to self-manage psychological symptoms and "reducing any ongoing dependency on the interdisciplinary team and services". The need to increase the patient's physical demand level (PDL) and further decrease his psychological symptoms does not provide an "individualized care plan explaining why improvements cannot be achieved without an extension". The documentation provided does not adequately address this requirement. The patient has completed his detoxification from opioid medication and has benefited from a standard program. Based on the documentation provided, ODG criteria were not met. It is recommended that the request for 10 additional sessions of chronic pain management is not reasonable or necessary. I contacted Mr. who is authorized to discuss this case. Treatment goals, the patient's current psychological status and the need for additional sessions were discussed. Mr. stated the additional sessions were needed to increase the patient's PDL's and further decrease his psychological symptoms. The information provided did not justify extending the program beyond recognized standards and guidelines. I uphold the adverse determination."

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

Patient has completed previous physical therapy, work hardening, and currently a pain program, which appears to have accomplished significant goals, although follow-up scores are not available to compare with baseline. Part of the request for extension above the usual and customary 20 sessions is with regard to patient needing to be returned to a very heavy PDL. However, pre-program FCE states that 'Patient reports that the maximum weight he is required to lift...on a frequent basis is 60 pounds.' Patient has currently exceeded the frequent basis PDL of 60 pounds. Additionally, patient does not fit into the category of an "outlier", based on his background, diagnoses, and symptoms. Therefore, given the remarkable amount of intervention patient has received, patient appears to have plateaued and medical necessity for a 10-day program extension is not warranted as reasonable and necessary, per ODG.

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**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**