

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 05/17/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: APPEAL-Chronic Pain Management Program -24 Hrs (4
hrs/x1 session/x6 months, 97799 Request Received Date 03/10/2011

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury when a 300 pound roll of insulation fell onto his left knee.

The employee is status post left knee partial meniscectomy and chondroplasty on 03/30/09. MRI of the left knee performed 03/06/09 demonstrated a large bone fragment associated with mid to distal PCL, probably related to an old avulsion injury to the posterior-central proximal tibia. There were prominent intrasubstance degeneration and partial thickness tears involving the middle two-thirds of the PCL without evidence of complete disruption. The anterior cruciate ligament and collateral ligaments were intact with mild maceration along the free edge of the body and posterior horn of the medial meniscus. There was suggestion of a partially discoid medial meniscus. There were complex tears seen throughout the lateral menisci, to include horizontal tears involving the body and anterior horn of the lateral meniscus, and an oblique horizontal tear involving the posterior horn of the lateral meniscus reaching the inferior articulating surface. There was patchy Grade III chondromalacia mainly throughout the medial and patellofemoral compartments. There was very subtle subchondral marrow edema underneath the medial and lateral distal femoral condyle anteriorly located. There was small joint effusion and mild proximal distal patellar tendinosis.

The employee completed eighteen sessions of physical therapy from 05/28/09 through 08/10/09.

A Functional Capacity Evaluation (FCE) was performed on 08/26/09. The employee's occupation as a required a heavy physical demand level. The employee was currently capable of performing at a light physical demand level.

The employee was seen for Designated Doctor Evaluation on 12/02/09. The employee complained of left knee pain rating 2 to 5 out of 10. Physical examination revealed the employee ambulated with an antalgic gait, favoring the left side. There were well-healed portal scars in the infrapatellar area anteriorly in the left knee. There was no tenderness, no joint crepitation, and no joint swelling. The deep tendon reflexes were 2/4 and equal bilaterally. There was no evidence of deficit to light touch or sharp touch. There was full muscle strength throughout. The employee was assessed with left knee medial meniscus tear and left knee lateral meniscus tear with partial meniscectomies. The employee was placed at MMI as of 09/22/09 and assigned a 4% whole person impairment.

Radiographs of the left knee performed 01/12/10 demonstrates no evidence of fracture. There was moderate loss of joint space medially and moderate to severe loss of joint space in the lateral joint space.

An FCE was performed on 08/26/10. The employee's occupation as a required a heavy physical demand level. The employee was capable of performing at a sedentary physical demand level. The employee was recommended for participation in a chronic pain management program.

The employee was seen for behavioral medicine evaluation on 09/01/10. The note stated the employee appeared mildly to moderately depressed and anxious. The

employee complained of severe pain in the left knee rating 5 out of 10. The employee reported sleep disturbance due to pain. Current medications included Hydrocodone, Flexeril, Xanax, and Paxil. The employee denied any preinjury history of psychiatric treatment. The employee's BDI score was 14, indicating mild to moderate depression. The employee's BAI score was 12, indicating mild to moderate anxiety. The employee's GAF score was 58. The employee was recommended for interdisciplinary chronic pain management.

An FCE was performed on 12/01/10. The employee's occupation as a required a heavy physical demand level. The employee was capable of performing at a sedentary to light physical demand level. The employee was recommended for additional sessions of chronic pain management.

An FCE was performed on 01/24/11. The employee's occupation as a required a heavy physical demand level. The employee was capable of performing at a light physical demand level. The employee was recommended for a chronic pain management aftercare program.

The employee was seen for behavioral medicine evaluation on 01/27/11. The note stated the employee appeared moderately depressed and anxious. The employee complained of severe pain in the left knee rating 5 out of 10. The note stated the employee completed twenty sessions of interdisciplinary chronic pain management in January 2011. The employee benefitted from these sessions by reducing his reliance on narcotic medication, increased activity levels, discontinued use of a cane, and improved functional capacity. Current medications included Hydrocodone, Naprelan, and Paxil. The note stated the employee would like to return to work; however, he did not currently have any specific plans for return to work or job retraining. The employee's BDI score was 24, indicating moderate depression. The employee's BAI score was 27, indicating severe anxiety. The employee's GAF score was 60. The employee's PAIRS score was 91, falling in the high range and in the "dysfunctional" category. The employee was recommended for chronic pain management aftercare.

The request for chronic pain management after care was denied by utilization review on 02/18/11 as the employee has completed 160 hours of chronic pain management and had been unable to return to work. The employee's BDI and BAI scores continue to be elevated, and the employee's Pairs score was still in the severely dysfunctional range. The employee exhibited multiple pain behaviors during the most recent psychological evaluation. Given the employee's overall lack of response to 160 hours of chronic pain management, continuation of chronic pain management at a significantly spaced out interval would not reasonably improve the employee's still continuing severe psychological issues.

The request for chronic pain management after care was denied by utilization review on 03/17/11 as the employee had not shown significant improvement. The employee has reduced medications, but had not eliminated them. Given the employee's overall lack of response to 160 hours of chronic pain management program, continuation of the program at a significantly spaced out interval would not reasonably improve the employee's still continuing severe psychological issues.

Electrodiagnostic studies performed 03/29/11 were consistent with left peroneal mononeuropathy at the fibular segment and generalized bilateral lower extremity peripheral polyneuropathy.

The employee saw Dr. on 04/13/11 with complaints of constant pain in the left knee with associated numbness and tingling. The employee also reported occasional popping of the left knee. Current medications include Lisinopril/HCTS, Actos, Metformin, Xanax, Hydrocodone, Paxil, and Lovastatin. Physical examination revealed the employee ambulated with an antalgic gait. Range of motion of the left knee was from 0 to 120 degrees. There was no sensation at the superficial peroneal nerve on the foot. The employee was assessed with left knee lateral and medial meniscal tear status post meniscectomies. The employee was recommended for chronic pain management aftercare. The employee was prescribed Hydrocodone, Xanax, and Neurontin.

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

The request for chronic pain management aftercare for six months, once a month, for four hours a session is not recommended as medically necessary. The employee has completed 160 hours of a chronic pain management program and continues to have significant psychological findings and no clear plans to return to work. Given the employee's significant psychological findings and pain behaviors noted on the most recent behavioral evaluation, there is no indication that the employee responded with any significant improvement to chronic pain management practices. It is unclear from the clinical notes how a chronic pain management aftercare program will further improve the employee's functional status and the chances of the employee to return to work.

Given the lack of clinical rationale on the functional improvements expected from a chronic pain management aftercare program and the limited improvement of the employee to chronic pain management treatment, medical necessity is not established.

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

Official Disability Guidelines, Online Version, Pain Chapter

Chronic Pain Management Program

(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.