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DATE OF REVIEW: April 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Program x 10 sessions. CPT Code: 97799.

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

FAMILY PRACTICE

PRACTICE OF OCCUPATIONAL MEDICINE

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

The date of injury is xx/xx/xx, which is to the lower extremity and to involve the knee. At the current time, we are x months post injury. This is a male with internal derangement of the left knee.

I have documentation of a Synvisc injection as of August 24, 2010, by M.D. Dr. awarded the patient a 1% whole person impairment rating based upon the Fourth Edition of the AMA Guides, under Table 64. Flexion of the knee was seen to be greater than 110 degrees.

There is an impairment rating with M.D. This was performed on November 10, 2010. The patient was assigned a 4% impairment rating based upon Table 64. It is noted that the functional capacity evaluation was considered invalid due to the limited effort. His active range of motion in flexion was only seen to be 105 degrees and extension was zero degrees.

M.D., in his assessment of the functional capacity evaluation describes it as "totally invalid." Dr. also states, "I am afraid he was refusing things out of fear of hurting himself, but it does not make physiological sense with what test he did perform."

I have the examination findings of January 31, 2011, which is approximately three months ago. The mechanism is described as a twisting of the patient's left knee during a fall. An MRI was reviewed to demonstrate a torn meniscus of the left knee with a flipped fragment and bone contusion. The patient underwent surgery on November 9, 2009, with substantial persistence of symptoms following surgery. There was a second surgery recommended to repair a chondral defect. This was denied as neither reasonable nor necessary. There were three injections into the knee performed by M.D. The type of injection is not specified in this report; however, in my opinion, it may have been some type of Synvisc or viscosupplementation of the knee joint. The assessment was left knee meniscal tear, effusion, and muscle spasm.

There was a functional capacity evaluation requested by evaluating physician, D.O. The patient was placed on Tramadol for pain and Flexeril for spasm. The recommendation was for a chronic pain

management program.

There is an evaluation from Healthcare Systems on February 3, 2011. The assessment was chronic pain disorder. The patient was recommended for an interdisciplinary chronic pain management program. The long-term and short-term functional goals were made. This is reported by L.P.C.

There is corroboration of a previous recommendation for a comprehensive pain management program of approximately 20 sessions as of evaluation on February 3, 2011, at Healthcare Systems.

There are results of a physical performance evaluation from February 3, 2011. This corroborated the previous determination of a light physical demand level with lifting up to 20 pounds occasionally and 10 pounds regularly.

I have what appears to be a peer review by D.C. This was performed on February 18, 2011. A review of the medical records reveals additional information. It is noted that the patient was felt to have achieved maximum medical improvement as of October 26, 2010, and was awarded a 1% impairment rating due to functional deficits. This was reassessed by M.D. The date of maximum medical improvement was November 10, 2010. The patient was awarded a 4% whole person impairment rating. It is noted that a chronic pain management program was recommended up to ten sessions for consideration as of the date of this consultation. The evaluating peer reviewer does take into consideration the ODG Guidelines recommendations and observations, which includes being a patient as a poor predictor of long-term outcome and the fact that a chronic pain management program has little scientific evidence for long-term effectiveness compared with other rehabilitation facilities. It was felt that chronic pain management was neither reasonable nor indicated, per the reviewing evaluator.

The necessity of a chronic pain management program was appealed as of February 21, 2011, by D.O., and D.C., and it was felt to be reasonable and necessary. The criteria for inclusion in a chronic pain management program were discussed, per the ODG Guidelines.

A review of the patient's functional capacity evaluation on follow-up visit of March 17, 2011, indicated he could function within the light physical demand level to include maximum lifting of 20 pounds and 10 pounds frequently. The recommendation was for an additional 12 sessions of physical therapy and IC counseling.

There was a second peer review performed by M.D., which corroborated an adverse determination. His rationale included only the minimal depression and mild anxiety noted. There were no significant psych issues identified to support the need for current treatment.

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

I am asked if a chronic pain management program for ten sessions would be reasonable and necessary. I have to concur with the previous determinations that it is neither reasonable nor necessary, as the Occupational Disease Guidelines has specifically stated that functional improvement is the goal in all of these therapies. The patient's most recent functional capacity evaluation revealed him to be severely self limited with a completely invalid test. As such, the likelihood of material change in his clinical condition in such a program would be unlikely. The previous levels of psychosocial barriers to include anxiety and depression were seen to be mild, and therefore, of little significant functional limitation. Two previous evaluators have determined that the patient had achieved clinical maximum medical improvement, which is defined as plateau in clinical status, which is unlikely to change. As such, I cannot state that there would be any expectation of material change in his condition with this particular modality. It has been 16 months since the patient's surgical intervention, and this is a more than adequate period of time for healing from such an intervention.

The patient's weight listed in the medical records is approximately 246 pounds. The greatest barriers to his return to function would be his obesity. Weight reduction would play a far greater role in pain management than returning him to a higher level of function with regards to his knee.

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)