



## IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

---

### 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: Reconsideration of Forte's NON-AUTHORIZATION of outpatient comprehensive pain management program (CPMP) times ten (10) sessions as related to the left knee. Original decision UPHELD. Recommend NON-AUTHORIZATION.

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

Texas Licensed Chiropractor

**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**

1. 10/09/08 - MRI Left Knee
2. 11/13/08 - Electrodiagnostic Studies
3. 02/10/09 - Operative Report
4. 03/25/10 - Clinical Note - D.C.
5. 11/10/10 - Massage Therapy Note
6. 11/10/10 - Special Focus Group Notes
7. 11/10/10 - Relaxation Group Notes
8. 11/22/10 - Physical Conditioning Notes
9. 11/23/10 - Massage Therapy Note
10. 11/23/10 - Special Focus Group Notes
11. 11/23/10 - Assertiveness Group Notes
12. 12/15/10 - Clinical Note - M.D.
13. 01/04/11 - Physical Conditioning Notes
14. 01/04/11 - Massage Therapy Note
15. 01/04/11 - Special Focus Groups Notes
16. 01/04/11 - Relaxation Group Notes
17. 01/12/11 - Clinical Note - M.D.
18. 01/12/11 - Physician Progress Note
19. 01/27/11 - Functional Capacity Evaluation
20. 02/04/11 - Physician Progress Note
21. 02/11/11 - Letter -

- 22.03/23/11 - Physician Progress Note
- 23.03/24/11 - Peer Review - M.D., MBA
- 24.03/28/11 - Letter of Medical Necessity - M.D.
- 25.03/31/11 - Request for Pre-Authorization for Additional Chronic Pain Management
- 26.04/04/11 - Notice of Utilization Review Findings
- 27.04/13/11 - Request for Reconsideration for Additional Chronic Pain Management
- 28.04/20/11 - Notice of Utilization Review Findings
- 29.04/27/11 - Physician Progress Note
- 30.Official Disability Guidelines**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on xx/xx/xx while transporting a large cart of milk which shifted. In an attempt to keep it from falling, she felt pain in the left knee.

An MRI of the left knee performed 10/09/08 demonstrated diminution of the posterior horn of the medial meniscus, compatible with degenerative tearing. There was maceration of the root attachment region of the posterior junction zone and body of the medial meniscus. There was severe degeneration and/or fraying of the anterior horn of the lateral meniscus. There was tricompartmental osteoarthritic changes, which were fairly advanced in the medial and patellofemoral joint compartments where full thickness chondromalacia was present. There was small knee joint effusion with synovitis within the joint space. There was nonspecific edema in Hoffa's fat pad. There was a small Baker's cyst. There was edema adjacent to the medial collateral ligament, likely a sequelae of mild sprain of this structure or from reactive edema related to osteoarthritis and meniscal tearing.

Electrodiagnostic studies were performed 11/13/08. Nerve conduction testing revealed reduced amplitudes of proximal tibial nerves. The distal tibial nerves were non-diagnostic due to edema. The EMG was unremarkable.

The employee underwent left knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, chondroplasty of the medial femoral condyle and tibial plateau, partial synovectomy, steroid injection, and peripheral nerve block at the infrapatellar branch of the saphenous nerve on 02/10/09.

The employee saw Dr. on 12/15/10 with complaints of left knee pain. The employee had completed ten sessions of a chronic pain management program, and she stated she felt the left leg strength had improved. Physical examination revealed restricted range of motion of the left knee. There was decreased strength of the left hamstrings. Deep tendon reflexes were active and symmetrical. The employee was recommended to continue with rehabilitation. The employee was prescribed Voltaren gel and Ultram.

The employee saw Dr. on 01/12/11 with complaints of left knee pain. Physical examination revealed restricted range of motion with pain. Mild crepitus was noted. There was weakness in the left lower extremity. The employee was assessed with left knee internal derangement syndrome status post left knee surgery. The employee was prescribed Voltaren gel and Ultram.

A note dated 01/12/11 stated the employee complained of constant left knee pain rating 5 out of 10. Physical examination revealed decreased range of motion of the left knee. McMurray's was mildly positive. The employee was recommended for a Functional Capacity Evaluation (FCE).

An FCE was performed on 01/27/11. The employee's occupation required a medium physical demand level. The employee was capable of performing at a sedentary physical demand level.

A note dated 02/04/11 stated the employee complained of constant, throbbing left knee pain rating 5 out of 10. Physical examination was not performed. The employee stated she felt more mobile and was able to stand and walk longer with less pain after completing fifteen sessions of chronic pain management. The employee stated she would like to continue the sessions.

A note dated 03/23/11 stated the employee complained of constant, throbbing left knee pain rating 7 out of 10. Physical examination was not performed. The employee was recommended for additional chronic pain management sessions.

A letter by Dr. dated 03/28/11 stated the employee had received six sessions of individual psychotherapy and two sets of ten sessions of chronic pain management with good results. The letter stated a total knee replacement had been recommended, but was being disputed as related to the compensable injury. The employee rated her average pain at 5 out of 10. Physical examination revealed mild appreciable edema about the right knee. There was palpable and audible crepitus with right knee motion. The employee was intolerant to McMurray's due to pain in the right knee with forced flexion. Apley's compression was positive for increased knee pain. Reflexes and sensation were intact and bilaterally symmetrical in the upper and lower extremities. The employee's BDI score was 32, indicating severe depression. The notes indicated her prior BDI score was 23. The employee's BAI score was 31, indicating severe anxiety. The employee's prior BAI score was noted to be 39. The employee's ODI score was 52/100, placing her in the severely disabled range. The note stated the employee had no job to return to. The employee was felt to be a good candidate for additional treatment in an interdisciplinary chronic pain management program.

The request for outpatient comprehensive pain management program times ten (10) sessions as related to the left knee was denied by utilization review on 04/04/11. The employee completed fifteen sessions of a chronic pain management program between November 2010 until January 2011. The documentation reported the employee suffered from an arthritic condition of the knee for which surgery was recommended. The documentation did not address why it had taken three months to provide fifteen sessions of the program and why there has been two months since those sessions were completed before additional sessions were requested. This pattern was more consistent with a re-enrollment than a continuation of the program.

The request for outpatient comprehensive pain management program times ten (10) sessions as related to the left knee was denied by utilization review on 04/13/11 as there was no significant objective and functional progress reported after fifteen sessions of chronic pain management. The average pain level remained at 5 out of 10, and the

claimant continued to function at a sedentary physical demand level. The depressive symptoms had increased on the Beck Depression Inventory from moderate to severe range, and scores on the ODI and FABQ remain unchanged. The claimant had completed fifteen sessions of the chronic pain management program over a five month span of time. The claimant continued to be a surgical candidate. The request was not reasonable or necessary and does not meet current **Official Disability Guidelines** at that time.

A note dated 04/27/11 stated the employee complained of intermittent left knee pain rating 6 out of 10. The employee used a cane for ambulation. Physical examination revealed decreased range of motion secondary to pain. There was decreased strength with left knee extension. McMurray's causes sharp left knee pain. There was 2+ edema of the left knee. The employee was recommended for additional chronic pain management sessions.

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

The requested chronic pain management program for 10 sessions for the left knee is not recommended as medically necessary. The employee has completed a previous chronic pain management program for fifteen sessions that failed to facilitate a return to work. The employee did not exhibit any significant objective improvement with the previous chronic pain management program, and there was no indication from the clinical notes that the employee was actively seeking a return to work. Current evidence-based guidelines do not recommend re-enrollment in identical chronic pain management programs, and given that the employee completed a previous program with no significant progress, it is unlikely that the employee will further improve with a second program.

As the clinical documentation does not support re-enrollment in a second chronic pain management program, 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***

ODG Pain Chapter

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 examination 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.