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Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 4, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic Pain Management Program – Initial 10 days

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 15 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 February 23, 20XX there is an Emergency Department Triage Form which states that the claimant has come in after tripping over a planter and landing on her left knee cap hearing a pop, unable to bend her left knee. The claimant rates her pain at 7/10. The procedure history states application of long leg splint, thigh to ankle or toes. The musculoskeletal assessment states left knee swollen and tender to touch; unable to bear weight and snapping sensation severity of pain rated at mild.

On February 24, 20XX there is an x-ray of the left knee 1 /2 V LT the Report states this is a normal study. Two views of the left knee show no fracture, dislocation or effusion, which was dictated by MD.

On February 24, 20XX there is a prescription for Ultram 50mg prn pain.

On February 27, 20XX there is a work related injury report (Insurer) by NP. The musculoskeletal/neurological assessment states there is mild ecchymosis along the lateral and anterior side of the knee. There is some ecchymosis also noted to the shin area, approximately mid shin and then just anterior to the mid shin and then just anterior to the mid shin area. The claimant is able to extend the knee. The claimant has point tenderness along the anterior knee. Claimant has tenderness on palpation to the posterior knee. Claimant has a positive McMurray sign, this did cause her a lot of pain and she became very tearful when I did that. There is no noted medial or lateral laxity. Claimant has pain and when I did the Lachman's testing there was no noted laxity, though. Clinical impression/diagnoses: 1 knee sprain; knee contusion; 2. leg contusion. Medications: Anaprox DS, Skelaxin 800mg, Ultracet 37.5 mg.

On March 3, 20XX there is an MRI L WR Ext any Joint w/o contrast-left. The impression states: 1. abnormal signal seen within the popliteus tendon and proximal lateral collateral ligament proper. Findings are consistent with mild partial thickness tearing. No surrounding edema is present and this is likely chronic in nature. The report was dictated by MD.

On March 9, 20XX there is a follow up appointment with NP. In the musculoskeletal/neurological assessment which states the claimant is using her crutches to walk and her knee immobilizer in place. There is some noted mild ecchymosis along the shin area of the left lower leg. There is no noted ecchymosis today in the knee area. There is not noted edema or erythema. The claimant states most of the pain in to the lateral side of the knee and the posterior part of the knee. The claimant has pain when the Lachman's testing was attempted. There is no noted medial or lateral laxity, but the claimant did have pain. The clinical impression was: knee sprain, knee contusion, lateral collateral ligament strain vs. rule out tear, leg contusion.

On April 14, 20XX there is a radiology report for knee 4 views-left. The impression states unremarkable plain radiograph examination of the left knee. The report was dictated by MD.

On April 14, 20XX there is an Orthopaedic surgery consultation dictated by MD. The physical examination states the claimant has pain that limits her flexion to about 60. She complained of bruising around the leg and knee. On my exam, I could not observe any bruising. Recommend switch to a hinged brace so she can regain some range of motion. Claimant requested Percocet which was to not appropriate 6 weeks post injury, the need for surgery was not seen at this point.

On May 12, 20XX the claimant was seen for a follow up appointment by MD. The physical examination states there is no effusion of the knee. There is no discoloration. She has good range of motion. Her lateral collateral ligaments have a symmetric amount of laxity with the opposite knee and a good endpoint. The medial side is stable. Strength of the ankle flexors and evertors intact. Sensation is intact on exam today. The impression states "I think she had a sprain of her lateral collateral ligaments. The MRI showed some edema laterally. By exam, she does not have any residual objective laxity. She is reporting some numbness, tingly feelings down the foot and leg in the peroneal nerve distribution. However, on exam today, her peroneal nerve function is intact.

On May 13, 20XX there is a physical therapy report by PT. The assessment states the claimant demonstrates signs and symptoms with left lateral collateral ligament sprain or possible tear. The claimant is able to perform gait approximately 5 feet without her crutch, but this exacerbates her symptoms, and the claimant must rest. The claimant's gait cycle is antalgic throughout entire cycle. Significant left lower extremity weakness limits standing and gait activity. Patient is using her crutch in her left upper extremity. She did attempt to use this in the proper positioning, which would be in her right hand. However, she states she was unable to do this, and this increased her pain. The patient demonstrates poor patellar tracking with knee extension. She is performing approximately only 50% weight bearing through her left lower extremity during gait cycle. Claimant does not perform heel strike with initial contact phase of gait, and she maintains knee extension through much of swing phases of gait. Claimant is able to correct this temporarily with verbal cues. However, she does not maintain correct form secondary to pain. The claimant would likely benefit from skilled physical therapy for strengthening and stretching, therapeutic exercises, modalities as needed for pain control, gait training, functional activity training, manual therapy and home exercise program.

On June 9, 20XX the claimant attended a follow up appointment with MD. The physical examination states: she has no effusion of either knee. She has good range of motion. She has a negative Lachman's test. She has no varus, valgus or posterior instability. She does have a little popping in her patellofemoral mechanism, but is nearly the same as the opposite knee. The impression states: I think this should be improving quicker than it is. Her symptoms do not really match the MRI findings. MRI suggested a possible lateral collateral ligament injury. She has no laxity of that ligament. Has no tenderness over that area. I think some therapy exercises should help. I do not see any reason why this should not be improving. I do not recommend any surgery for this. We will have her follow up with the work related injury doctors so she can manage her return to

work issues. I will have our clerks book her physical therapy appointments. Hopefully they can arrange to try some physical therapy on her knee. She is dismissed

On June 29, 20XX there is a Workers' Compensation Work Status Report by MD. The report states that the claimant may return to work with restrictions: work 4 hr/day in a sedentary capacity, the diagnoses were knee contusion, left knee sprain.

On July 11, 20XX there is a Physical Therapy report by PT. The claimant rated her pain 6/10. The assessment states the claimant performs all therapeutic exercises today, reporting exacerbation of symptoms. Treatment today was followed with ice for 15 minutes. Claimant continues to demonstrate antalgic gait; however, this has decreased.

On July 20, 20XX there is a Physical Therapy progress report by PTA. The note states that the claimant rates pain at 5/10. Objective: Electrical Stimulation at interferential to the left knee for 15 minutes with CP, and therapeutic exercises.

On July 23, 20XX there is a Physical Therapy Re-evaluation by PT. The assessment states the claimant demonstrates progression towards goals at a rate slower than expected for this type of injury. She continues to demonstrate significant tenderness with palpitation, and also does not perform full weightbearing to her left lower extremity in standing or gait activities. She is able to achieve appropriate hip flexion and knee flexion during swing phase. She no longer performs circumduction during swing phase of gait. Claimant continues to require verbal cue3s to perform dorsiflexion during initial contact phase of gait, but is able to perform this without exacerbation of symptoms. The claimant would likely benefit from continued physical therapy exercises, modalities as needed for pain control, gait training, functional activity training, and home exercise program progression until follow-up with her physician.

On August 3, 20XX there is a weekly late progress note for Physical Therapy. The objective portion of the note states left knee passive range of motion is 0 degrees, flexion is 130 degrees, left knee range of motion extension 0 degrees, flexion 105 degrees. The assessment states the claimant tolerates all therapeutic exercises with exacerbation of symptoms which she states resolves with electrical stimulation and ice following treatment. However, claimant does state her generalized 4/10 pain level remains the same.

On August 10, 20XX there is a Physical Therapy discharge summary by PT. The left knee Range of Motion extension is 0 degrees, flexion 103 degrees. Left knee passive range of motion extension is 0 degrees and flexion is 130 degrees. The assessment states the claimant is progressing towards goals at a slower rate than expected for this type of injury. She continues to perform entire gait cycle with limited left knee active range of motion flexion. Although the range is available, she does not utilize this during swing phases of gait. The claimant is able to achieve adequate left knee flexion through swing phases of gait when

verbally cued. She tolerates all therapeutic activities with minimal exacerbation of symptoms.

On August 27, 20XX there is a Workers' Compensation Work Status Report that states the claimant has received an injury that prevents her from returning to work from 8-27-20XX through 9-27-20XX. The diagnosis is left knee injury

On August 27, 20XX there is a History and Physical by DO. Physical examination states claimant is wearing a knee brace. She has laxity of the left knee on testing. She has a negative drawer sign. She has mild effusion. She has numbness, tingling, and dysesthesia down to the foot and toes. The impression states left knee sprain/strain; internally deranged left knee; disuse atrophy.

On October 7, 20XX there is a Workers' Compensation Work Status Report that states the claimant is unable to return to work related to an injury to her left knee from 10-07-09 through 11-07-09. The diagnosis given is left knee injury.

On October 7, 20XX there is a follow up appointment with DO. Impression states left knee sprain/strain; internal derangement, left knee; probably tear of the lateral collateral ligament, left knee.

On October 8, 20XX there is a Physical Therapy Evaluation, claimant rates her pain 7/10, X-Ray normal, MRI March 20XX, Meds Darvocet N100, assistive device hinged knee brace; the lower extremity ROM flex: 95 degrees, ext:-3 degrees, Ext. Lag: -3 degrees; strength L knee flexion is 4/5, extension 4/5.

On October 20, 20XX there is a report from Clinic by PTA. The assessment states the claimant was provided with written HIP and demo for all exercises. Claimant was provided with one on one instruction for proper body mechanics and techniques. Claimant was able to demo good understanding of exercises. Claimant was instructed to perform HEP 3 x daily and was informed of progression of exercises.

On October 20, 20XX there is a statement of medical necessity DME equipment/medical supplies for a green theraband.

On November 12, 20XX there is a follow up note from DO which states objective: she has a decreased range of motion in the left knee on flexion and extension. She has a mild left knee effusion. She has numbness, tingling, and dysesthesia down to her foot and toes. The impression states left knee sprain/strain and internal derangement, left knee.

On November 18, 20XX there is an initial behavioral medicine consultation by LPC-Intern/ MS, CRC, LPC, Clinical Supervisor. Under the Detectable positive effects of treatment on patient's overall condition and course of recovery states: the initial evaluation that we completed in our office suggests that claimant would greatly benefit from a brief course of individual psychotherapeutic intervention to

facilitate a healthy adjustment and improve her coping with her physical work injury of X/Xx/XX. This should assist her in developing to tools and skills for the management of her injury-related distress. The patient should receive immediate authorization for participation in a brief low level of individual psychotherapy for 6 weeks. Should her function fail to improve and mood symptoms fail to abate, she may be a highly suitable candidate for a comprehensive rehabilitation program.

On November 18, 20XX there is a behavioral addendum which states: testing administered: results of the Beck Depression Inventory-II and the Beck anxiety Inventory real the following: the claimant scored a 14 on the BDI-II, indicative of mild depression. She scored a 15 on the BAI, indicative of mild anxiety. Some incongruence is noted between the patient's BDI/BAI and VAS endorsements, as well as clinical observations.

On December 17, 20XX there is an individual psychotherapy note by MA, LPC Intern. Under patient self report it states the claimant reported that her lawyer is possibly closing her case. She is concerned about her treatment and would like to RTW. The wreck she had in XXXX has made her pain worse and she is concerned about how to pay for bills and Christmas. Observations: dysthymic, affect constricted. Axis I is adjustment disorder with mixed anxiety and depressed mood, secondary to the work injury.

On December 29, 20XX there is an individual psychotherapy note by LPC.

On January 5, 20XX there is an individual psychotherapy progress note by MA, LPC which states under the self report that claimant reported that she fell last week and her knee popped out. She is having considerably more pain now. She is going to the knee surgeon on the 11<sup>th</sup>. She is having more trouble sleeping due to increased pain. Under current medications: Darvocet.

On January 11, 20XX there is a report from MD which is the claimant's self completed medical history.

On January 14, 20XX there is an individual psychotherapy progress note by MA, LPC which states under the self report that claimant reported to the orthopedic surgeon saying that she is having too much pain for x years after her injury. He wants to do surgery. Claimant is happy to be getting treatment but is anxious about surgery as well. She does not react well to anesthetic. This has affected her sleep.

On January 28, 20XX there is an individual psychotherapy progress note by MA, LPC which states under the self report that her surgery has been denied because of her 4% IR. She wants to dispute that. Medication: Darvocet.

On February 9, 20XX, there is an individual psychotherapy progress note by MA, LPC which states under the self report that the claimant's grandfather died and the increased travel and helping with cleaning has increased pain and muscle tension.

On February 10, 20XX there is a Treatment Summary/Reassessment at Clinic by MA, LPC. Under the overall progress section it states mild improvement in the areas of sitting, standing, walking, home exercise, anxiety, sleep, and frustration. Mild worsening in pain, depression, and muscle tension partly due to increased relationship stressors exacerbated by pain.

On March 17, 20XX there is a Peer Review by MD. Which states based on the medial records provided, the claimant has reached a plateau in treatment I do not believe that psychotherapy is related to the compensable injury. After the Designated Doctor Evaluation, the claimant should have been placed on maintenance care only and discontinue the use of Darvocet and only utilize an over the counter anti-inflammatory medication. There is no indication for the ongoing use of any DME, referrals, and active physical therapy. The claimant should be performing a daily home exercise program for strengthening. The claimant has returned to work without restrictions. Medical records reflect the claimant has some atrophy at the left lower extremity which has not totally resolved. However, based on the documentation provided the effects of the compensable injury does not appear to have resolved, but has certainly reached a plateau in treatment on or about 10-3-XX. The atrophy should resolve with home exercise program and return to work.

On May 6, 20XX there is a Workers' Compensation Work Status Report which states will allow the employee to return to work May 6, 20XX without restrictions. The diagnosis is left knee injury.

On May 6, 20XX there is a follow up note by DO which states the claimant has a decreased range of motion in the left knee on flexion and extension. She has a mild left knee effusion. She has numbness, tingling, and dysesthesia down to her foot and toes. The impression states left knee sprain/strain and internal derangement of the left knee.

On June 10, 20XX there is a follow up note by MD which states under the physical exam the claimant does show some pain over the lateral aspect of the knee with decreased flexion. She has fairly good extension. She does still have a small left knee effusion. Describes numbness, tingling, and pain down the leg as well. The impression states left knee sprain/strain, partial thickness lateral collateral ligament tear of the left knee, internal derangement of the left knee. Plan is to refill the Darvocet N-100, 600 tablets.

On July 8, 20XX there is a follow up note by MD. The physical exam states she shows good range of motion to flexion and extension of her knee. She has some tenderness over the superior aspect of her knee with some very minimal swelling. She does not show much of a joint effusion that I can appreciate today. She has a negative Lockman test, negative evidence of any joint instability. Impression states left knee sprain/strain; possible partial thickness tear of the left lateral collateral ligament, possible tear in the popliteal tendon.

On July 9, 20XX there is a re-evaluation at Clinic by DC. The assessment states the claimant demonstrates likely persisting tear of lateral collateral ligament and possible internal derangement. I agree that an orthopedic consultation is indicated at this time. The orthopedic support is not a perfect fit but is still offering support to the knee and is beneficial.

On July 12, 20XX there is an encounter note by MD. Stated in the physical findings no swelling or asymmetry about the left knee is noted. She is diffusely tender even to light touch posteromedial corner, anteromedial joint line, direct anterior over patellar tendon, anterolateral joint line, and posterolateral corner. She has range from 0-120 degrees flexion with mild discomfort at extreme flexion. She has no valgus or varus instability. Negative anterior drawer, negative pivot shift. The assessment states left knee strain, posterolateral corner strain with likely interval healing, mild chronic pain condition.

On August 5, 20XX there is a Workers' Compensation work status report that states will allow the claimant to return to work without restrictions 8-5-XX.

On August 5, 20XX there is a follow up report by MD which states she has full range of motion of her knee. She really has no point tenderness that I could appreciate. She has full range to flexion and extension. She is ambulating without any obvious discomfort. Darvoct N 100 60 tablets 1 po tid prn pain.

On August 11, 20XX there is a re-evaluation by DC. The assessment states because of the amount of physical therapy that was already performed including the home exercises, she is not likely to have an improved outcome with additional physical rehabilitation at this time. Also, considering the lack of subjective improvement, and functional deficit for the amount of time that has passed since the injury, there continues to be the possibility that internal derangement of the left knee may be present. A follow up MRI would be necessary to rule this out.

On September 2, 20XX there is a Workers' compensation work status report which states the claimant would be allowed to return to work as of 9-2-XX.

On January 20, 20XX there is a Workers' Compensation Work Status Report which states the claimant would be allowed to return to work 1-20-XX.

On January 20, 20XX there is a follow up report by MD. The physical examination states show better range of motion of her left knee, still a small effusion. She still has some pain with Varus and Valgus stresses of the knee. Negative Lachman. Impression is left knee sprain/stain and possible subclinical meniscal tear to the knee; plan work hardening program, tamadol, Mobic.

On January 26, 20XX there is a Functional Capacity Evaluation recommendation states pre-injury: sedentary; current PDL-light/medium. The claimant demonstrated the ability to RTW at her pre-injury level DDL of Sedentary, however, from by understanding she has been terminated from this position and

it is not currently available. Her pain continues to inhibit her abilities. Her testing demonstrates we are losing ground with the progression that we had already made so it is imperative that we continue her care as soon as possible. I agree with the assessments of Dr. and Dr. this claimant is a surgical candidate, however, the insurance company seems to be reluctant to approve the procedure. It is recommended that the claimant participate in a 10 day chronic pain management program designed specifically to reduce these issues and to assist her in returning to her normal ADL's or find a new vocation that would be better fit her injuries to prevent further damage and/or increased pain. Testing Analysis states the left knee at approximately ½ of the normal range of motion and measurement as follows: left flexion 49.3 (53% of normal) and extension left is 0.7 (101%) of normal.

On January 27, 20XX there is a health and behavioral re-assessment by, MS LPC-Intern/ MS, LPC, CRC. Under the detectable positive effects of treatment on patient's overall condition and course of recovery: The evaluation that we completed in our office suggests that the claimant would greatly benefit from a work hardening program. She continues to struggle with marked pain and functional limitations, which pose difficulty to performance of routine demands of living and occupational functioning. She demonstrated elevated fear avoidance. The claimants treating doctor is recommending participation in a Work Hardening program to advance the patient's physical condition and function and support the patient's desire to return to work and resumption of other major obligations. Given the information gathered during the evaluation, the claimant is a good candidate for the Work hardening program and her psychosocial problems may be effectively addressed in didactic group therapy services offered in this program.

On January 27, 20XX there is an Assessment/Evaluation by MS LPC Intern for Work Hardening Program. In the Mental Status Exam Axis I: Pain Disorder, associated with both psychological factors and a general medical condition, Chronic. Conservative treatment has been exhausted and the claimant is therefore recommended for participation in the Work Hardening Program.

On February 24, 20XX there is a Workers' Compensation Work Status Report that states the claimant will be allowed to return to work as of 2-24-XX.

On February 24, 20XX there is a History and Physical Chronic Pain Management Program by MD. In the musculoskeletal examination it states: her left knee shows a moderate amount of pain and tenderness with minimal range of motion. She does chronically wear a knee brace. She has got pain with Varus and Valgus stresses, negative anterior drawer, and negative Lachman maneuver. No joint instability, but she did have a small effusion.

On February 24, 20XX there is Chronic Pain Management Interdisciplinary Plan and Goals of Treatment.

On March 14, 20XX there is a Request for Initial 10 day Trial in a Chronic Pain Management Program; this states: We are requesting 10 days of an interdisciplinary Chronic Pain Management Program (CPMP) for the claimant. To start we summarize her case information as we establish the medical necessity for this intervention for this claimant at this time, with subsequent review of ODG criteria and OCOEM guidelines for treating chronic pain. The summary states prior treatment modalities have failed to stabilize the claimant's psychosocial distress, increase her engagement in activities of daily living, or enhance her physical functioning such that she could safely return to work. The claimant is approximately 8 months status post injury. Her pain is described a chronic, persistent, and intractable at 7-9/10. She demonstrates obvious functional deficits since the injury that impact her daily functioning. Less intense levels of care have appropriately been attempted and have failed. All other appropriate treatment has been ruled out. Surgical intervention has been ruled out. She has developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. The claimant's treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this patient's pain experience, develop self-regulation skills, facilitate a timely return to the work force, and obtain medical case closure. The Texas Labor Code 408.021 is then cited.

On March 17, 20XX there is an initial determination letter from Insurer to the claimant denying services. Under pertinent clinical information/rationale: The claimant is a XX year old female who has history of chronic left knee pain. According to a CPMP evaluation on 3/14/XX, there was mention that the claimants' treatment included medications, physical therapy, crutches, knee immobilizer, and counseling sessions. Also per 3/14/XX note, there was mention that a previous MRI revealed an abnormal signal within the popliteus tendon and proximal lateral collateral ligament proper consistent with mild partial thickness tearing as well as degenerative signal in the medial meniscus with no meniscus tear and a tiny joint effusion. Also per 3/14/XX note, there was mention that the claimant's medications included Tramadol and Mobic and that a focus in the CPMP would be to titrate the Tramadol. According to a previous FCR on 1/26/XX, the claimant was mentioned as functioning at a light-medium PDL with a job requirement of PDL of sedentary. Also per FCE report, there was mention that the claimant was determined to be a surgical candidate, but that the insurance company did not approve this. In a psychological evaluation on 1/27/XX, it was determined that the claimant was a good candidate for a work hardening program. There is no support from the available documentation/information that the claimant requires a chronic pain management program at this point. The claimant is already functioning at a reasonably high overall functional level above her original job requirement PDL. Also there was mention of the claimant was determined to require surgery in the past and if there is a surgical lesion, a chronic pain program is not indicated. The claimant is also not on any narcotic medication management that would require aggressive weaning through a CPCM as well. There was also a discrepancy in the previous psychological evaluation in which a work hardening program was recommended

and not a chronic pain program. Therefore, the requested chronic pain management program x 10 days is not medically reasonable or necessary.

On March 17, 20XX there is a letter from Insurer to Clinic This letter states that after review of the medical information presented and/or discussion with the medical provider, an Insurer Physician Reviewer has determined that the health care service requested does not meet established standards of medical necessity. This letter is a carbon copy of the above.

On March 31, 20XX there is a Workers' Compensation Work Status Report which states the claimant would be allowed to return to work 3-31-XX.

On March 31, 20XX there is a follow up report from MD. The physical examination states shows good range of motion today, but it does show some moderate pain over the medial meniscal area to palpation. A small joint effusion is appreciated as well. Negative Lachman's. Impression states left knee sprain/strain, medial meniscal tear to the knee, degeneration of the medial meniscus of the left knee.

On April 4, 20XX there is Reconsideration: Request for Chronic Pain Management Program by Clinic. This response is directed at the denial dated 3-17-XX by Dr.. At the time her intake was done (1/27/XX), the claimant was under the XX years from her date of injury and would have been considered a work hardening candidate. However, since her date of injury is XX years old, WH is no longer appropriate per ODG guidelines. The claimant might have met her sedentary PDL but she does not have that job to return to. She is currently working full time with restrictions. She is struggling to maintain her work duties and is wearing a knee brace. She is currently working as a worker. Our goal is to get her to a medium PDL and for her to work without restrictions. The claimant continues to take Tramadol 50 mg and Mobic 15 mg and despite this, endorses a pain level of 8/10 depending on her level of activity. The claimant has chronic pain syndrome and has noted dependence/reliance on family members for basic ADLs such as cleaning and yard work, these were activities she easily completed prior to the work injury. She has obvious secondary physical deconditioning, evidenced by her inability to perform at her functioning level of Sedentary. She is currently assessed as being capable of a Light/Medium PDL. The claimant reports that, since her injury participation in family and social activities is often limited, due to pain. She has failed to restore her pre-injury level of function at this point, evidenced by the PPE, and has not returned to work and indicated non-involvement in recreational activities. The claimant has endorsed minimal depression, she does not report fear avoidance of activities at work. The claimant has not been diagnosed with a personality disorder or psychological condition without a physical component. The claimant continues to take Tramadol 50 mg and Mobic 15 mg and despite this endorses a pain level of 8/10 depending on her activity level. The claimant has motivation to change, is willing to change her medication regimen, and is aware that successful treatment may change secondary gains; she describes her relationship with her employer before the injury as good. ODG guidelines are stated and noted, chronic pain diagnosis

is related to American Medical Association, American Academy of Pain Management, and American Academy of physical Medicine and Rehabilitation, and the Texas Workers' compensation Mental Health Treatment Guidelines, also referenced is the ACOEM. The summary states: The summary states prior treatment modalities have failed to stabilize the claimant's psychosocial distress, increase her engagement in activities of daily living, or enhance her physical functioning such that she could safely return to work. The claimant is approximately X months status post injury. Her pain is described a chronic, persistent, and intractable at 7-9/10. She demonstrates obvious functional deficits since the injury that impact her daily functioning. Less intense levels of care have appropriately been attempted and have failed. All other appropriate treatment has been ruled out. Surgical intervention has been ruled out. She has developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. The claimant's treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this patient's pain experience, develop self-regulation skills, facilitate a timely return to the work force, and obtain medical case closure.

On April 7, 20XX there is a letter from Insurer to the claimant which states the physician advisor appeal upheld/non-certification of a chronic pain management program initial 10 day trial. Under pertinent clinical information/rationale the letter states: this is a XX year old female claimant status post injury X/XX/XX. 3/17/XX non certification determination identified that the claimant is already functioning at a reasonably high overall functional level above her original job requirements PDL, physical findings and previous MRI identify knee pathology that maybe amenable to further treatment options including surgery, and the claimant is also not on any narcotic medication management that requires aggressive weaning in the context of a chronic pain management program. 4/4/XX response to 3/17/XX determination identified subjective findings that include chronic pain, numbness, tingling, and dysesthesia in the left lower extremity. Objective findings include uses crutches to ambulate, tenderness with minimal range of motion, pain with varus and valgus stresses, small effusion. Imaging findings include degenerative signal in the medial meniscus with no meniscus tear identified; tiny joint effusion. Conservative treatment includes physical therapy, medication, and counseling. Discussion identifies that she has chronic pain with dependence on family members for activities she easily completed prior to the injury; obvious secondary physical deconditioning; participation in family and social activities is often limited due to pain; minimal depression, Oswastry score moderate at 24%; takes pain medication and still has pain at 8/10;she has completed a physical performance evaluation that outlines her physical capabilities and deficits; claimant has motivation to change, is willing to change her medication regimen, and s aware that successful treatment may change secondary gains; negative predictors of success have been addressed; the claimant is no longer at the prior job which was a sedentary PDL but is working with restrictions at a job that is a medium PDL; and continues to take Tramadol 50 mg. Evidence based guidelines necessitate documentation of chronic pain syndrome, with evidence of loss of function that persists beyond three months; previous methods of evaluation ha s

been made; a treatment plan has been presented with specifics for result in significant clinical improvement; the claimant has motivation to change, and is willing to change their medication regimen including decreasing or actually weaning substances known for dependence; negative predictors of success have been identified; and the outcomes for the necessity of use have been clearly identified. Within the medical information available for review, the has not had an evaluation identifying there are further interventional treatment options, including surgery, to treat the knee pathology; and specific documentation of pain medication regimen with or without substance abuse issues that necessitates management in the context of a chronic pain management program. Therefore, the request is not certified.

On April 7, 20XX there is a carbon copied letter from Insurer to claimant as noted above.

On April 7, 20XX there is a facsimile transmission cover sheet from LVN/Insurer to PhD which state 4/7/XX physician advisor appeal upheld/non-certification of a chronic pain management program initial 10 day trial. Recommendation: Non-certify.

On April 7, 20XX there is a Request form; request for a review by an independent review organization (3 pages).

On April 20, 20XX there is letter from Attorneys and Counselors which states this request for IRO involves a request for preauthorization of a chronic pain management program which has been denied as not medically necessary pursuant to the Official Disability Guidelines. The letter then summarizes the medical records that were sent under separate cover.

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

No pertinent medical history. Surgical history is positive for appendectomy and her wisdom teeth removed.

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

Denial of 10 days Chronic Pain Management Program is overturned. Per the reconsideration letter dated 4/4/XX the claimant meets all criteria for CPM per ODG: pain for more than XX years, evidence of loss of function, deconditioning, withdrawal from social activities, continued prescribed Tramadol and Mobic, unsuccessful previous treatment, surgical intervention has been ruled out. She has had psychosocial vocation evaluation and individual psychotherapy. She does not have substance abuse problems and she is motivated. Based on the above mentioned the claimant meets the criteria per ODG therefore, the previous decision is overturned.

**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)