

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 5, 2011

**IRO CASE #:**

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

97799 Chronic Pain Management Program x 10 days

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

This physician is Board Certified 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**

Employers First Report of Injury or Illness: Date of Injury: xx/xx/xx. Part of body injured: Knees. How and Why Injury/Illness Occurred: Other-not classified.

On xx/xx/xx, the claimant was evaluated by MD for right knee pain. PE: Right knee had tenderness to palpation over the medial meniscus with positive McMurrays sign. Negative anterior durus sign. Minimal effusion. Plan: Knee

brace and prescriptions for Naprosyn 500 mg, Toradol 60 mg, and Lortab. Recheck in 1 week to see if a MRI was needed.

On October 2, 2010, the claimant was evaluated by, PAC and, MD who ordered x-rays of the right knee and recommended continuing Naprosyn. X-rays of the right knee showed osteoarthritis and cartilage loss of two compartments of the knee along with joint effusion as interpreted by MD.

On November 10, 2010, the claimant had a follow-up evaluation with PAC who recommended a MRI of the right knee.

On December 6, 2010, the claimant had a Functional Capacity Evaluation at Accident & Injury Rehab by DC. Based on the results she demonstrated the ability to perform in the Sedentary physical demand level. It was recommended she attend an active therapy program.

On December 16, 2010, the claimant was evaluated by MD who diagnosed right knee derangement, torn medial meniscus, high probability of partial injury to ACL postero-lateral bundle. He recommended a MRI of the right knee, Ultram, and possibly an arthrogram and repair.

On December 16, 2010, MRI of the right knee without contrast interpreted by MD. Impression: Severe tricompartmental osteoarthritic change. Large degenerative tear posterior horn medial meniscus and meniscal root. Subchondral insufficiency fracture on the medial femoral condyle without evidence of articular surface collapse.

December 22, 2010 – January 11, 2011, there are many daily notes from Accident & Injury Rehab during this time frame.

December 30, 2010, Peer Review by MD. Opinions rendered: Based on review of the medical records and based upon reasonable medical probability, the claimant sustained an injury to the right knee as described. Medical records support significant degenerative change in the knee prior to the injury event at issue. She may have a clinically significant medial meniscal tear which would benefit from arthroscopy. Within reasonable medical probability, this is related to the injury event. There is insufficient evidence to suggest an ACL tear is related to the injury event at issue. The degenerative arthritis is unrelated to the injury event at issue. Treatment thus far appears in accordance with the ODG.

On January 13, 2011, the claimant was re-evaluated by MD who diagnosed right knee derangement, torn medial meniscus, right ACL laxity. He recommended an arthrogram and repair.

On March 14, 2011, operative report by MD. Procedures performed: Arthroscopic ACL repair, Arthroscopic removal synovium and/or adhesions (patellofemoral/extensor/suprapatellar, medial, lateral, anterior, intercondylar), Arthroscopic medial and lateral meniscal repair, Arthroscopic lateral

retinacular/capsular release, Autologous soft tissue transfer, graft harvest site distant from surgical field.

On April 17, 2011, the claimant was re-evaluated by MD 4 weeks post op. The right knee was stable. Dr. recommended home exercises and physical therapy.

April 18, 2011 – May 13, 2011, there are many daily notes from Rehab during this time frame.

On May 16, 2011, the claimant had a Functional Capacity Evaluation at Accident & Injury Rehab by DC. Based on the results she demonstrated the ability to perform in the Sedentary physical demand level. It was recommended she continue with her post surgical rehab.

On July 7, 2011, the claimant was re-evaluated by MD who noted she has improved despite carrier refusing additional needed therapy. It was also noted that according to the claimant her employer would not allow return to work with restrictions. Dr. stated that she may need additional care in the future, but at the present time did not need ongoing additional surgical care. Therefore, he referred her back to her treating doctor, Dr. and signed off on regular follow up.

July 11, 2011 – July 28, 2011, there are many daily notes from Accident & Injury Rehab during this time frame. Pain was consistently reported as 3/10.

On July 26, 2011, the claimant had a Mental Health & Behavior Assessment at Lighthouse Behavioral Health Services by PhD. The evaluation was requested by DC to evaluate her need and appropriateness for participation in a Chronic Pain Management Program at Rehab. It was reported that she experiences persistent right knee pain with radiations into her right leg that are described as: flickering, jumping, boring, pressing, burning, tingling, sore, and tender. Pain is present during her waking hours and ranges in intensity from 3-8 on a 1-10 VAS. Diagnostic Impressions and Recommendations: Objective testing, patient reports and behavioral observations yield symptomology consistent with a diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood; and Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. The overall severity of symptoms appears to be mild. The claimant has expressed a willingness to participate in the Chronic Pain Management Program at Accident and Injury Rehab and she appears to be an appropriate candidate. Due to the nature of the claimant's psychological, physical and psychosocial symptoms, she is an appropriate candidate and would benefit from treatment in an Interdisciplinary Chronic Pain Management Program 80 hours.

On July 28, 2011, the claimant had a Functional Capacity Evaluation at Rehab by DC. Based on the results she demonstrated the ability to perform in the Light physical demand level. Her job required demand level is Light. It was opined that she is unable to meet her job requirements for standing, walking, pushing, and pulling, which she is required to perform those duties constantly. It was recommended she attend a Chronic Pain Management Program.

On August 10, 2010, PhD performed a UR on the claimant. Rationale for Denial: A Functional Capacity Evaluation dated 7/28/11 notes that she is at light physical demand level and has a required demand level of light. She was working as a before her injury and continued to work until she had surgery on 3/10/11, but she has not reportedly attempted to return to work since. She rates her pain as 3-8/10 and is taking Hydrocodone. She is noted to have some symptoms of anxiety, depression, and fear-avoidance but they are not severe. Therefore, she does not appear to meet the physical criteria for a pain program per evidence-based guidelines.

On September 6, 2011, MD performed a UR on the claimant. Rationale for Denial: Per Functional Capacity Evaluation, meets physical demand level to be at work. The records document a long history of leg aches and pains and known history of arthritis. Current medications over-the-counter analgesics and prn Hydrocodone. Erroneous notation in the file per MD about an ACL repair-no ACL repair was approved and there is no basis to assume one performed in 71 year old with no demonstrated instability. Claimant does not meet Criteria #1 for Chronic Pain Management Program participation. She is reportedly motivated to return to work, has financial incentive to be at work, is not taking much medication and has a demonstrated strong work ethic. The barrier to her returning to work and a release from care appears to be the practice pattern of her treating provider, who is reportedly a Dr., who referred her to Dr., DC.

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

The claimant reported she was pushing a cart and she suddenly felt a sharp pain in her right knee.

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

Denial of Chronic Pain Management x 10 days is upheld. Per ODG Pain Chapter, criteria #1(d) is not met. There is no loss of function demonstrated: Current FCE reveals Light physical capabilities equivalent to her preinjury job demands.

## **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)**