

**AccuReview**  
An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** December 28, 2011

**IRO CASE #:**

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

80 hours of chronic pain management program

**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:**

07-22-11: MRI left knee interpreted by  
10-29-11: Designated Doctor Exam performed by  
11-09-11: Functional Capacity Evaluation performed by  
11-09-11: Medical Report by  
11-09-11: Behavioral Health Assessment by  
11-15-11: Case Summary  
11-17-11: Preauthorization Request by

11-23-11: UR performed by  
11-29-11: Preauthorization Reconsideration by  
12-06-11: UR performed by  
12-08-11: IRO Request letter by

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

The claimant is a female who injured her left knee on xx/xx/xx while she was pushing crates. She was treated with medications, physical therapy and underwent left knee arthroscopy in February 2010. Her left knee pain was not improved and therefore she underwent a left total knee arthroplasty in March of 2011. Following surgery she was diagnosed with reflex sympathetic dystrophy and has been treated with physical therapy and pain management and underwent a sympathetic block injection of the lumbar spine in September of 2011.

07-22-11: MRI left knee interpreted by. Impression: 1. Small joint effusion. 2. No meniscal tear. 3. Focal chondral defect along the mid to posterior aspect of the medial femoral condyle with underlying subchondral cystic change which measures 0.8x1.2 cm in size with subchondral cystic change. 4. Patellar chondromalacia high grade along the lateral patellar facet towards the apex and along the medial patellar facet as described above.

10-29-11: Designated Doctor Exam performed by. On physical examination the claimant's right thigh was measured to be 42 cm and her left was 36 cm. Her right calf was measured to be 26 cm and her left was 24 cm. Her left knee ROM was 10 to 80 degrees both passively and actively. She had pain throughout the range of motion. Her alignment was normal. Her left knee and medial quad were slightly redder compared to the right. There was no significant temperature difference between the right and left knee and it did not appear hot or warm. There was good stability to varus and valgus stress of the knee. She had decreased sensation laterally to the incision there was some tenderness with light touch and slight hypersensitivity medial to the incision as well as down the medial leg. This appeared to be in a saphenous nerve distribution. Quadriceps strength was 4/5. diagnosed status post left total knee arthroplasty, complex regional pain syndrome, and arthrofibrosis left knee. opined the claimant had reached MMI as of July 22, 2011 with a 30% whole person impairment. also opined that he did not think that anything else could be done medically to improve the knee and leg. was asked to address the extent of the compensable injury with regards to reflex sympathetic dystrophy and in his opinion he believed that reflex sympathetic dystrophy was compensable. He further stated that he thought she would require ongoing pain management treatment as her symptoms may wax and wane and change over the course of time. Lyrica seemed to work but she could not tolerate because of her eyesight. She was awaiting approval of Neurontin.

11-09-11: Functional Capacity Evaluation performed by. Impression: The claimant presented with poor to fair endurance during testing. Moderate pain behaviors were noted during testing. During testing, the claimant appeared to be putting forth maximal

effort. Poor body mechanics were demonstrated during most testing procedures. The claimant demonstrated functioning closest to the medium work level as classified by the Dictionary of Occupation Titles. This was determined when the claimant demonstrated the ability to lift 50 pounds on an occasional basis from 12 inch to knuckle and 25 pounds on a frequent basis from 12 inch to knuckle. The claimant's job was classified in the heavy category. Recommendation: The claimant would benefit from a interdisciplinary rehabilitation program by addressing issues related to chronic pain, by improving overall functional level and by learning coping and pain management skills.

11-09-11: Medical Report by. noted he had been treating her for RSD and that she underwent a lumbar sympathetic block without relief. She continued to have pain and used a brace. She was placed on Celebrex and Lyrica with adverse drug reaction to Lyrica. Neurontin was prescribed by had been denied by the insurance company. On physical examination she walked with an antalgic gait favoring left lower extremity. Diagnosis: Status post left knee injury with total knee replacement with chronic pain. Recommendation: Interdisciplinary rehab program at.

11-09-11: Behavioral Health Assessment by. Psychological Test Results: Validity scales indicated valid test protocols although her profile suggested possible problems with under-reporting and an attempt to present herself in a positive light. Responses were consistent with individuals who tend to report physical complaints in response to stress. Responses on other inventories suggested she was experiencing at least mild depressive and anxiety symptoms. The claimant appeared to perceive herself as substantially impaired due to pain which she perceived as being intolerable. Diagnostic Impression: Axis I: pain Disorder a/w both psychological and medical factors. Axis II: Diagnosis Deferred. Axis III: Chronic Pain Syndrome, left knee pain. Axis IV: Chronic Pain, occupational problems, limited social support. Axis V: GAF=60. Recommendations: The claimant was an appropriate candidate for a n interdisciplinary rehabilitation program that focuses on functional restoration. She presented with severe left knee pain with significant functional limitations. Treatment goals should include increasing physical functioning, improving her ability to perform physical tasks, as well as increasing strength, mobility, and endurance. In addition, treatment should focus on increasing her pain tolerance and education on managing chronic pain while monitoring her emotional distress.

11-15-11: Case Summary by. It was reported that the claimant had completed a series of biofeedback/relaxation training and individual counseling sessions. The claimant was reported to have made some progress in gaining insight/awareness into the relationship between daily stressors, her cognitive and emotional response, her physiological arousal and her level of pain. It was also reported that the claimant continued to report significant levels of pain and physical impairment. Her pain level throughout her treatment had ranged from a 4/10 to a 10/10. She continued to report sleep disturbance, fatigue, decreased appetite, decreased libido, anxiety, and depression. It was noted that the pain behaviors and cognitions would likely require a more comprehensive approach that could effectively address pain related disability in a n

experiential context emphasizing functional restoration. It was recommended that a more intensive, multi-disciplinary chronic pain program would be of great benefit.

11-17-11: Preauthorization Request by.

11-23-11: UR performed by. Reason for Denial: The clinical indication and necessity of this procedure could not be established. The psychological evaluation of 11/9/11 finds impressions of pain disorder and chronic pain syndrome. However, this is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The psychometric assessment is unrevealing an inconsistent with behavioral/psychological contributing factors to a chronic pain syndrome; and there is no 'thorough behavioral psychological examination' to provide a reasonable 'manifest explanation for the etiology and maintenance of patient's clinical problems' (i.e., pain complaint, behavior, and disability), to enable a 'better understanding of the patient in their social environment,' or to provide 'a cogent explanation for the identified complaints and dysfunction.' The ADL are described only generically; through there are references to other reports to antalgic gait, there is no supporting behavior analysis; and the MMPI-2-RF result alluded to in the above evaluation is inconsistent with any behavioral/psychological contribution. The only finding may be minimal to moderate pain and related complaints, which is understandable. The request document of 11/17 notes that the patient 'exhibits severe pain behavior,' but there is no behavioral assessment to suggest that factors other than the underlying condition of the knee are contributory. The current history and physical by the program medical director, (11/9) does not actually include an exam. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. There is apparent ambiguity regarding the diagnosis of CRPS; and there was no positive response to the sympathetic block. The patient reportedly had an adverse reaction to Lyrica; and Neurontin was apparently denied, per the requester. However, there has been no follow-up to this or other attempts to medically treat the problem or conduct further diagnostics, as suggested by the above DDE. I am not able to establish a basis that this treatment is both reasonable and necessary at this time.

12-06-11: UR performed by. Reason for Denial: A DDE recommended further medical assessment of this injury. Thus, there is no evidence provided to indicate that the treatment team has exhausted all appropriate treatments for this patient, a clinical indication for a chronic pain management program. Thus, the request is inconsistent with the requirements that 'there is an absence of other options likely to result in significant clinical improvement' and 'all diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnostics), should be completed prior to considering a patient a candidate for a program'. This injury is over 2 ½ years old, thus, the etiology and maintenance of the patient's pain complaints have not been adequately assessed. The request is inconsistent with the requirement that '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'. The 'duration' of this injury is a negative predictor of success and is not adequately addressed in the evaluation. ODG recommends 'an adequate and thorough multidisciplinary evaluation' and negative predictors of success above have been addressed' before the appropriateness of a chronic pain management program can be determined. There is not an 'adequate and thorough' multidisciplinary evaluation of this patient to determine the appropriateness of a chronic pain management as required by current guidelines. Based on the documentation provided, ODG criteria were not met.

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

Denial of Chronic Pain Management is agree upon/upheld since ODG criteria are not met. There is lack of formal evaluation-there is no notation of formal/thorough physical exam, particularly recent ROM about the knee and no notation of psychometric testing and the change/benefit from individual psychological sessions/relaxation sessions (ODG Pain Chapter Criteria #1). There is no notation of the number of postop PT visits to determine if lower level PT was beneficial or exhausted (ODG Pain Chapter Criteria #2). There is notation of FCE indicating medium physical capability versus heavy job demand, but no notation of specific goal to return to function, (whether there is a job to return to versus if there are secondary plans) particularly given greater than 24 months of disability (ODG Pain Chapter Criteria #s 6 & 9).

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)**