

SENT VIA EMAIL OR FAX ON  
Jan/03/2012

## Applied Assessments LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Jan/03/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Chronic Pain Management Program 10 sessions (5 X a week X 2 weeks) Related to Right Knee/Leg Injury as an outpatient

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
PM&R and Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Notice of denial of pre-authorization 12/06/11  
Notice of reconsideration 12/15/11  
Pre-authorization request for CPMP 12/01/11  
Initial interview 10/26/11  
Functional capacity evaluation 08/30/11  
Reconsideration request for CPMP 12/12/11  
Request for reconsideration 12/09/11  
Request for medical dispute resolution 12/19/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female whose date of injury is xx/xx/xx. The claimant reportedly injured her right knee when she stepped into a hole causing her to trip and fall landing on her right knee.

Records indicate the claimant has exhausted all other physical therapy benefits. She does not have a job to return to, and is going to go to vocational rehabilitation program. Claimant is noted to have participated in individual psychotherapy. Beginning BDI was 29 and decreased to 20. BAI started at 50 and was down to 42. Accordingly the claimant was recommended to participate in chronic pain management program. A peer-to-peer discussion was completed with Dr. who stated that the request is for the knee. Claimant reportedly has exhausted lower levels of care including physical therapy and individual psychotherapy. She has shown some improvement in response to individual psychotherapy. According to Dr. pain management program is the only thing she can do as she cannot do work hardening or work conditioning because she needs a job to return to. It was noted she would benefit from intensive psychotherapy with physical therapy to reduce her pain. Her pain from knee sprain/strain continues to be 7 or 8, pretty constant at 7. The request for 10 sessions of chronic pain management program was determined as not medically necessary for sprain strain of the knee. No MRI findings were obtained. It was noted the claimant should be doing home exercise program, but Dr. did not know if she was doing that either.

A reconsideration request was reviewed on 12/15/11, and the request for chronic pain management x 10 sessions for chronic right knee pain was determined as not medically necessary. Peer to peer discussion was completed with requesting chiropractic Dr.. It was discussed that there were no clinical findings to substantiate or explain claimant's subjective complaints. Dr. indicated the claimant has had MRI in past which revealed meniscal tear. It was discussed that if there is meniscal tear it needs to be treated because no amount of physical therapy or psychological therapy is going to allow for progression of symptoms as long as pathology is still there. Dr. indicated the major problems are because the only compensable injury accepted has been strain / sprain of knee. It was discussed there are no clinical findings other than subjective complaints of pain. There were notes from orthopedic surgeon indicating what has been recommended or diagnosed. The records do not indicate the claimant is using extensive amounts of opiate narcotics or multiple concurrent medications such as neuromodulators or other analgesics. There is no indication how much physical therapy the claimant has had or what treatments she has had. There is no indication she has tried any type of work conditioning or work hardening. There is no indication of what her response to physical therapy has been. There is no indication of any treatment involving injections, nerve blocks. In regards to psych issues, there is no indication of any significant problems with household maintenance, sleep, weight control, hygiene maintenance, socialization, or loss of emotional control. At this time, request for admission into functional restoration program (interdisciplinary pain management program) is recommended for non-certification as not being medically reasonable or necessary.

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

Based on the clinical information provided, the request for chronic pain management program 10 sessions is not recommended as medically necessary, and the two previous denials are upheld. There are no objective findings documented to support the patient's subjective complaints. The patient has reportedly undergone an MRI of the right knee; however, the report of this study was not submitted for review. The submitted records appear to indicate that the MRI shows a meniscal tear. If this is the case, then the meniscal tear should be treated prior to consideration of a chronic pain management program as no amount of physical therapy and/or individual psychotherapy will allow for progression of symptoms. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)