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November 24, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Behavioral Health Evaluation for Participation in 10 day (80 hours) trial period of pain management program.

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

Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old female who was injured on XX/XX/XX. The patient was walking into her work space when her left foot caught some extension cables that were connected to a refrigerator and she tripped injuring her left knee/leg.

On March 6, 2015, the patient was seen at for pain in the left knee/leg rated at 8/10, exacerbated by prolonged standing. Examination revealed limited range of motion (ROM) of the left knee. The patient was diagnosed with obesity and left knee pain and discharged on Naprosyn and Tylenol #3.

On March 11, 2015, magnetic resonance imaging (MRI) of the left knee showed small knee effusion with posterior medial extravasations in a synovial Baker's cyst, patellar articular cartilage had an osteochondral defect with subchondral cysts and edema in subcutaneous soft tissues just inferior to the patella.

On March 23, 2015, the patient went to the emergency room (ER) again at xxxxxx and was diagnosed with left knee pain/effusion and recommended initiating physical therapy (PT) and continuing medications.

On April 13, 2015, the patient was seen at and recommended PT three times a week for three weeks.

From April 15, 2015 through May 4, 2015, there were eight sessions of PT documented.

On April 28, 2015, the patient, continued to have left leg pain rated at 5/10 and was continued on PT. Naprosyn was refilled and functional capacity evaluation (FCE) suggested.

On May 8, 2015, FCE placed the patient light physical demand level (PDL). She was recommended participation in work conditioning program (WCP).

On May 12, 2015, the patient reported worsening pain with prolonged standing and squatting. Examination revealed pain with internal rotation of the knee, effusion and limited range of motion (ROM). The patient was continued on the prescribed medications.

On May 14, 2015, the patient underwent a rehab reevaluation.

On May 27, 2015, the patient reported pain at 5/10. Joint examination showed ligamentous instability and limited range of motion (ROM). She was recommended continuing medications and work conditioning.

From June 1, 2015 through June 29, 2015, the patient complete her three weeks of WCP with mild to moderate irritability to the left knee.

On July 1, 2015, the patient returned to Clinic with pain rated at 5/10 with movements/bending/standing and squatting and better with rest. On examination, there was tenderness with medial and lateral joint line. X-rays were ordered and the patient was referred for orthopedic evaluation.

On July 13, 2015, the patient was seen for her left knee injury. The patient stated she was working modified duty. The patient complained of pain arising from a sitting position as well as ascending or descending stairs. The patient felt a popping sensation in her knee. An MRI scan showed a 3 small knee joint effusion with osteochondral defect in the articular surface. The patient had not worn a knee brace. reviewed the x-rays and noted good joint space with minimal degenerative changes. The right knee showed medial joint space narrowing. The MRI scan was reviewed and showed articular cartilage defect in the patella. He opined that the patient sustained direct trauma to her knee and might have injured the articular surface of the patella femoral joint and recommended a trial of an injection with steroid and anesthetic. Modified duty was continued.

On July 30, 2015, Physician's Record indicated the patient would benefit from the steroid injection recommended by the orthopedist. Naproxen was continued.

On August 17, 2015, administered Depo-Medrol injection into the left knee.

On September 5, 2015, the patient rated her pain at 3/10. She was diagnosed with internal derangement of the left knee.

On September 16, 2015, noted that the injection helped the patient for about weeks but then the pain returned. She still had swelling and felt a popping sensation in the anterior portion of the knee. She was unable to work a full eight hour shift due to pain and swelling. On examination, there was mild knee effusion, mild patellar facet tenderness. The motion was from 0-130 degrees of flexion. The patient was over months from her Injury of direct trauma to her knee. She most likely had an articular cartilage fracture of the patella. She had exhausted nonoperative treatment including rest, therapy, medication, and injection. As the patient had got temporary relief with the injection a diagnostic arthroscopy was recommended.

On September 25, 2015, the patient was evaluated for interdisciplinary pain rehabilitation program as she continued to have pain in the left knee. The pain was noted to be intermittent and aggravated when moving/stretching. She was prescribed a knee brace and compression stockings, rest, ice, compression and elevation (RICE) and work conditioning. The patient refused surgery.

Per utilization review dated September 30, 2015, Behavioral health assessment, each 15 minutes, was denied with the following rationale: *"Regarding the requested behavioral health assessment, 12 units, each 15 minutes, there is an absence of documentation noting that this patient has any psychological problems or behavioral problems as a result of the fall onto the left knee. There is no indication of mental conditions that would support the request for behavioral health assessment. Therefore, the request for behavioral health assessment, 12 units, each 15 minutes is neither medically necessary nor appropriate."*

On October 9, 2015, appealed for the denied Services of Behavioral Health Evaluation for Participation in 10 day (10 hrs) trial period of Pain Management Program to improve her physical and emotional functioning without the need of further treatment.

On October 9, 2015, in a letter of medical necessity wrote that the patient was an appropriate candidate for participation in an interdisciplinary pain rehabilitation program and that she would benefit from these services.

Per utilization review for reconsideration dated October 20, 2015, the denial was upheld. Rationale: *"The patient was diagnosed with a chronic left knee pain. The patient also underwent a left knee*

injection on August 17, 2015. The magnetic resonance imaging of the left knee dated March 11, 2015, documented that the knee bones were in normal alignment without evidence for an acute bony injury. There is insufficient objective information presented for review. There is no history of any anxiety, depression or psychological comorbidities that would impact the healing. There was no information regarding antidepressants or anti-anxiety medications. There is no unusual behavior documented regarding pain medications. It is unclear why the behavioral health assessment was recommended for the patient. The guidelines do not support a behavioral health assessment without specific objective criteria regarding psychological issues. Therefore, the request is not medically necessary.”

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

Based on the medical records and mechanism of injury there is no evidence to support the need of Behavioral Health Assessment. There is no documentation of anxiety, depression or psychological comorbidities or medications prescribed including antidepressants or anti-anxiety medications. There is no unusual behavior documented regarding pain medications. Records report normal range of motion, only an anti-inflammatory prescribed and pain scale of 5/10 clearly not necessary based on ODG for the need of the requested modality.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES