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IRO REVIEWER REPORT

TEMPLATE -WC

DATE: February 1, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program – 80 hours/units – Outpatient

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

The reviewer is certified by the American Board of Physical Medicine and Rehabilitation with over 20 years of experience.

REVIEW OUTCOME:

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

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 claimant is a male who injured his left knee when X a client while working on XX/XX/XX.

XX/XX/XX: Knee left 1-2 views report. IMPRESSION: Large knee joint effusion. No acute bony injury identified.

XX/XX/XX: The claimant was evaluated. He complained of 8/10 left knee pain after a twist injury resulting in pain and swelling at the proximal calf and medial and lateral knee as well as swelling. He complained of knee popping. He had been taking naproxen and hydrocodone 5/325 mg. Review of systems was remarkable for left knee muscle and joint pain and anxiety (takes meds). On exam, the left knee was swollen at the medial knee and warm; flexion 90 degrees; negative anterior and posterior drawer; negative medial and lateral collateral ligament testing; McMurray's positive at the medial knee. He was diagnosed with left knee strain – suspect medial meniscus tear. An MRI was ordered, and he was to return to clinic. He was given prescriptions for ibuprofen 800 mg and tramadol 50 mg. Restrictions – splint, crutches.

XX/XX/XX: MRI left knee report. IMPRESSION: Large hemarthrosis. Trabecular microfracture/bone contusion of the

posterior aspect of the lateral tibial plateau, about 3 cm in diameter. This presumably is the source of the hemarthrosis. Small focus of bone marrow edema in the fibular head adjacent to the marrow edema in the tibia, compatible with bone contusion. Tear of the anterior horn of the lateral meniscus with possible small flap or free fragment extending towards the midline of the knee adjacent to the anterior horn of the lateral meniscus. Small area of articular cartilage signal abnormality in the patella may be secondary to injury or degeneration.

XX/XX/XX: The claimant attended 15 sessions of physical therapy. A home exercise program was discussed.

XX/XX/XX: The claimant underwent left knee arthroscopy with partial lateral meniscectomy.

XX/XX/XX: The claimant was evaluated. It was noted that he was getting better every day. He rated his pain as 4/10. He was not having any more swelling and was having no more popping in his knee. He still had some weakness. It was noted that he had some quad atrophy prior to his operation, which was taking some time to get back. On exam, there was no swelling to his knee. He had good quad strength rated at 5/5 compared to the right, but he did have some muscle bulk compared to the right. His range of motion was from 0 to 125 degrees. His knee was stable to varus and valgus stress at 0 and 30 degrees of flexion. He still had some mild tenderness to palpation on the lateral joint line, but it was significantly improved from before his operation. PLAN: At this point, he does not feel like he is ready to go back to work. He does work as an officer at a juvenile detention center, which requires a lot of physical activity. He is getting better but slowly. He has a meeting with his Workers' Comp physician next month. I will see him in about the same time, and if he is feeling up to it, we will release him back to work. I want him to continue to work on his quad strength and range of motion.

XX/XX/XX: The claimant attended physical therapy sessions from XX/XX/XX through XX/XX/XX.

XX/XX/XX: The claimant was evaluated. He reported that he injured his back on XX/XX/XX while doing physical therapy for his work injury. It was noted that the pain was still ongoing and preventing him from doing more physical therapy at that time. He rated his left knee pain as 1-2 out of 10. It was noted that he was unable to run or get a fast walk. He complained of lower thoracic pain radiating around the turn as a paresthesia and shooting pain in a dermatomal pattern. He was unable to stand for long periods of time or sleep due to his back pain. His current medications included hydrocodone, Flexeril, and Mobic. On exam, He was able to rise unassisted. He was standing stooped forward about 10 degrees but was able to stand erectly to 0 degrees. He demonstrated full squat without support slowly. He was tender at the thoracic spine with palpable increased tone and tender spasm at the right thoracic paraspinal muscles. He had decreased sensation and paresthesia in a dermatomal pattern along the right thoracic intercostal ribs at about T10-T12. Right (as per this transcribed report) knee with healed surgical scars; not tender to palpation; anterior and posterior drawers were negative; McMurray's was negative; right knee flexion was 130 degrees, extension is 0 degrees; strength was 5/5 at bilateral hip flexors, knee flexion/extension, and ankle flexion/extension. It was noted that he was on his 2nd set of physical therapy which was going well for strengthening of his left leg, although he did experience a low back pain strain while in therapy which was continuing to be symptomatic with spasms. Physical therapy was on hold due to the back injury. The case was discussed with the physical therapist who reported no mechanism of injury or incident that could have caused a herniated disc. XX stated, "Therefore, I am not going to pursue adding the back injury as part of the compensable claim." For return to work: No running; unable to stand or walk for 4 hours a day. He was to follow up with new TD in 4 weeks, as this doctor was relocating. MMI status: At MMI still requires physical therapy for the left leg. IR: 4%.

XX/XX/XX: MRI lumbar spine report (page 1 of 2 only; no interpreting physician listed). IMPRESSION: Disc herniation at L5-S1; mild lumbar spondylosis and facet arthrosis; varying degrees of neural foraminal narrowing as denoted above.

XX/XX/XX: The claimant was evaluated. On exam, the left knee was noted for no evidence of any deformity, no edema, and no discoloration. There was some decreased active range of motion of the knee secondary to pain. There was no tenderness to palpation over the soft tissue structures of the knee joint. Otherwise, neurovascularly intact. IMPRESSION: Internal derangement left knee status post-surgical repair XX/XX/XX. Lumbar disc HNP at L5-S1. PLAN: UDS, FCE, MMI/IR second opinion, pain management consult, follow up X month, prescribed ibuprofen 800 mg

and tramadol hcl 50 mg.

XX/XX/XX: MMI/IR. The patient has not reached MMI.

XX/XX/XX: FCE. The evaluatee's required PDL is VERY HEAVY, but his current physical performance level is light.

XX/XX/XX: MMI/IR. The patient has not reached MMI.

XX/XX/XX: The claimant was evaluated. RECOMMENDATIONS: Patient has been denied work hardening program presumably because he has not completed lower level postop rehabilitation, therefore it is recommended that the patient receive postop rehabilitation to increase strength and functional tolerance and decreased pain. Patient appears very anxious and depressed, therefore I recommend a follow up with the treating doctor for possible referral for psychological evaluation.

XX/XX/XX through XX/XX/XX: The claimant attended physical rehabilitation sessions. The note indicates that it was visit number 5 of 10. ASSESSMENT: Patient was in a good and positive attitude. Patient performed his exercise; however, patient was complaining of pain and tension on his knee. Patient pain level after rehab remained the same, 3/10. PLAN: Continue with plan of care as tolerated by patient.

XX/XX/XX: The claimant was evaluated. It was noted that he was status post 5 of 10 physical rehabilitation sessions. His prescription had since expired. An extension had been denied and he was to be advanced onto a work hardening program.

XX: FCE. The evaluatee is unable to perform their regular job duties at this time. The evaluatee's required PDL is VERY heavy, however, their current physical performance level is LIGHT. The evaluatee was not able to perform several key functions crucial to the safe performance of their normal work duties.

XX/XX/XX through XX/XX/XX. The claimant attended a Work Hardening Program with XX.

XX/XX/XX: PPE. The evaluatee demonstrates functional deficits on evaluation today that would benefit from additional medical attention, including therapy and/or diagnostic testing; is unable to perform their regular job duties at this time; required PDL is VERY heavy, however their current physical performance level is Medium; was not able to demonstrate the ability to perform several key functions crucial to the safe performance of their normal work duties.

XX/XX/XX: MMI/IR. The patient has not reached maximum medical improvement. The employee has been participating in a work hardening program and making good progress. Treating doctor has recommended extension to the work hardening program to try and reach a performance level of very heavy for full duty RTW. The employee is expected to continue to improve while participating in a work hardening program.

XX/XX/XX: A Team Conference Note states that XX had completed 137 of his approved 160 hours of the WHP. His current PDL was medium lifting 65 lbs. It was noted that the team supported his efforts and anticipated he would make significant advancement toward his work required PDL of very heavy.

XX/XX/XX: Daily note notes that XX came in to program with a positive attitude. He performed well throughout the day. His pain level remained constant post program, 2/10.

XX/XX/XX: FCE. FINDINGS: The evaluatee is unable to perform their regular job duties at this time; required PDL is VERY heavy, and even though he is able to lift 100 pounds, he has a lot of instability as noted in the graph portion of the static lifting section. He was also required as a correctional officer to handle more weight than 110 pounds as some inmates are much heavier than that. The evaluatee was not able to demonstrate the ability to perform several key functions crucial to the safe performance of their normal work duties due to the instability of the left knee. Recommend participation in a chronic pain management program to further address mental and psychological issues that may be complicating the evaluatee's progress in their work hardening program and ultimately their return to

gainful employment.

XX/XX/XX: The claimant was evaluated: stated that he had completed the work hardening program and would benefit from a chronic pain program. On exam, he had no evidence of knee deformity, no edema, and no discoloration. There was some decreased active range of motion of the knee secondary to pain. There was no tenderness to palpation over the soft tissue structures of the knee joint. IMPRESSION: Pain persisting beyond 3-4 months post incident; depression accompanied by emotional upheaval and problems coping with life events; dysfunction (withdrawal from social disability from work, restrictions of activity of daily living); internal derangement left knee status post-surgical repair July 2014; lumbar disc HNP at L5-S1. PLAN: UDS, CPM program ordered, patient medically clear for CPM program, FCE ordered, follow up in 1 month, alprazolam 0.5 mg and ibuprofen 800 mg prescribed.

XX/XX/XX: The claimant was evaluated. BDI-II score 31, indicating severe depression. BAI score 7, reflecting minimal anxiety. FABQ-W 38, FABQ-PA 12. DIAGNOSIS: Somatic Symptom Disorder, persistent, mild; Major Depressive Disorder, severe. Recommend chronic pain management program.

XX/XX/XX: UR. RATIONALE: During the peer discussion, it was advised that the patient has completed work hardening. After completing a tertiary level program, the patient should be returned to work or referred to DARS for retraining. Another tertiary level program is not warranted.

XX/XX/XX: UR. RATIONALE: This is my fourth review of this case. The patient's BDI score has increased, indicating increased reports of depression, but all other subjective measures are less or equal than before. The patient continues to function at very heavy Physical Demand Level and job demand is very heavy. The request states he has general instability and deconditioning. However, on treadmill he was able to walk 9 minutes at a 14% incline. Note, the instability seems to be related to the graph portion of the Functional Capacity Evaluation. This does show inconsistency (e.g., coefficient of variation on left knee flexion is 18/.5%, an unacceptable indication of inconsistent effort, not instability). I believe the requestor is confusing inconsistency with instability. Will need to discuss psychometric testing, particularly the BHI-2 in depth, as it shows either severe psychological problems, a cry for help or a tendency to be overly dramatic. ODI is very low. FABQ scores are elevated. Spoke with XX at 9:00 AM on XX/XX/XX. I asked why he needs a Chronic Pain Management Program since he is at VERY HEAVY Physical Demand Level. He says on my end I need to go with whatever the team recommends. The chiropractor says he is unable to do a one-time lift but cannot endure an 8-hour day. I asked what the requestor means by instability, and he said he really could not determine how this was assessed. Given that the patient is already at very heavy Physical Demand Level, has had a work hardening program, and has limited psych issues, a Chronic Pain Management Program is not appropriate nor within ODG guidelines.

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

The previous adverse decisions are upheld. After completion of a full course of work hardening, the required very heavy physical demand level has been met, and therefore no demonstration of residual functional loss. The ODG have not been met. Therefore, the request for Chronic Pain Management Program – 80 hours/units – Outpatient is not of medical necessity.

ODG:

Chronic pain programs (functional restoration programs)	Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> 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
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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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. ([Sanders, 2005](#)) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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](#).

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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)