

# Vanguard MedReview, Inc.

101 Ranch Hand Lane

Aledo, TX 76008

P 817-751-1632

F 817-632-2619

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## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Program

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

This case was reviewed by a Doctor of Anesthesiology with experience in pain management with over 12 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]:

XXXX: Operative Report by XXXX. **Post-Operative Diagnosis:** Left knee medial meniscal tear.

XXXX: Office Visit by XXXX. **Assessment:** S/P knee surgery **Plan:** Patient still in the work hardening program.

XXXX: Office visit by XXXX. **HPI:** Patient is returning for a recheck of injuries: left knee pain is still the same, not any better. Waiting for the MRI. Pt is not working, works at the XXXX and states XXXX is unable to XXXX. XXXX did therapy for a short while, 3 sessions and XXXX states that has helped in the past. Pt is on XX and XX for pain.

XXXX: Office Visit by XXXX. **HPI:** Patient states XXXX is improving. XXXX is having popping, clicking, stiffness, and swelling. Pain is 7/10 and radiates from knee up to hip and down to ankle and gets worse when sitting and prolonged standing. Patient is taking XX and applying ice/elevate to help relieve pain. **Assessment:** 1. Tear of medial meniscus of left knee. 2. Chronic pain of right knee. **Plan:** XR knee 3 VWS Bilateral. I think we have done all that we can for this injury. I have told XXXX that XXXX can have a XX through XXXX but I can't do much otherwise.

XXXX: MRI Left Knee interpreted by XXXX. **Impression:** Complex tear of the posterior horn of the medial meniscus. Examination is limited by motion artifact. There is grade II sprain of the medial collateral ligament. There is a suprapatellar joint effusion and prepatellar bursitis and a popliteal cyst.

XXXX: Consultation by XXXX. **HPI:** XXXX states on XXXX, left leg hyperextended. XXXX had to have a surgery with XXXX, which was done in the early part of XXXX, medial meniscectomy,

posterior complex radial tear at the root. The patient has been off work since the injury. Diabetes and hypertension. Hip replacement in XXXX. **Medications:** XX, XX, XX, XX, XX, and XX. **Exam:** Knee ROM within normal limites. XXXX uses a cane to walk. **Assessment:** I believe there is no further interventional pain procedures or surgeries that are envisioned on this patient. XXXX would benefit from a chronic program for the ability to function at a higher level with decreased pain. XXXX will need 1, functional capacity evaluation at XXXX and 2, psychological evaluation at my office. This then will be submitted to WC for approval for a chronic pain program 10 sessions and possibly 10 more sessions for an increased function, mobility, decreased pain, decreased need for pain meds, and possible vocational counseling.

XXXX: UR performed by XXXX. **Rationale for Denial:** The guideline states, “Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.” And, the guidelines provide “Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help determine who will most benefit from this treatment. Retrospective research to evaluate screening tools prior to entry. (Gatchel, 2006) Three is a need for research in terms of necessity and/or effectiveness of counseling for patients considered to be “at-risk” for post-discharge problems. (Proctor, 2004) The following variables have been found to be negative predictors of efficacy of treatment with the employer/supervisor; (2) poor work adjustment and satisfaction: (3) a negative outlook about future employment: (4) high levels of psychosocial distress (higher pretreatment levels of depression. Pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking: (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain.” In this case, the claimant completed 160 hours of work hardening program, aqua therapy, injections, knee arthroscopy, and medications. XXXX continues with pain, stiffness, and weakness in the left knee. However, XXXX would not be considered a candidate for a chronic pain programs XXXX is recommended for knee replacement, and the negative predictor for success is not addressed (the claimant is an everyday smoker and is severely XXXX). Also of note is the FCE on XXXX showed the patient’s PDL is medium and PDL at work is unknown. Furthermore, XXXX has mild depression and anxiety per the behavioral evaluation on XXXX (BDI-II score of 9, BAI score of 8, SOAPP-R score of 5, and a Fear-Avoidance Belief Questionnaire (FABQ) score of 37 out of 42 for work scale and 10 out of 24 for activity scale). Medical necessity is not established in accordance with current evidence-based guidelines. The case discussed was with a representative, XXXX. Reviewed guidelines and rationale. A pain management program is not a substitute for a total knee arthroplasty, if one is needed. Recommend non-certification of chronic pain program.

XXXX: Letter of appeal by XXXX reported that patient might need a knee replacement. Patient has had Arthroscopy on XXXX knee (injury). XXXX has also had an injection. XXXX reports XXXX knee has been “repaired”. Patient also reached MMI rating therefore, has no pending surgeries. Patient’s scores on BDI and BAI need not be severe to qualify for the CPMP functional restoration program. Patient’s injury is over XX old and XXXX would like to get back to work.

XXXX: UR performed by XXXX. **Rationale for Denial:** I discussed the case with XXXX, a representative. Regarding the chronic pain program, we discussed that the patient does not meet criteria for the requested program. We discussed that typically, patients are not allowed to re-enroll in the same or similar rehabilitation programs. We also discussed that the evidence-based guidelines have clearly stated that treatment within a chronic pain program is not suggested for longer than 2 weeks without evidence of compliance and significant demonstration of efficacy and documented by subjective and objective gains. In this case, the patient has a low Beck depression inventory (BDI) and Beck anxiety inventory (BAI) and is functional at a medium physical demand level. As such, in accordance with the

previous denial, the request for 10 sessions/80 units of chronic pain program x 3 weeks is non-certified.

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

Based on records submitted and peer reviewed guidelines, this request is non-certified. Patient does not meet criteria for the chronic pain program. Typically, patients are not allowed to re-enroll in the same or similar rehabilitation programs. Per guidelines, treatment within a chronic pain program is not suggested for longer than 2 weeks without evidence of compliance and significant demonstration of efficacy as documented by subjective and objective gains. In this case, the patient has a low Beck depression inventory (BDI) and Beck anxiety inventory (BAI) and is functional at a medium physical demand level. As such, in accordance with the previous denial, the request for 10 sessions/80 units of chronic pain program x 3 weeks is not medically necessary and is non-certified.

**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)