I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Continue with Chronic Pain Management times 10 sessions (5 sessions per week for 2 weeks) (97799)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Certified by the American Board of Psychiatry and Neurology
Licensed by the Texas State Board of Medical Examiners

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 1/23/09, 2/13/09
Appeal Letter, 1/12/09, 11/14/08, 10/3/08, 1/12/09, 2/27/09, 2/11/09, 7/27/07
Initial Mental Health Plan & Eval, 5/30/08
Operative Report, 12/21/06, 3/27/08
Designated Doctor Evaluation, 1/13/09
MRI Left Knee, 12/6/06
MD, 4/8/08
MRI Left Knee, 2/6/08
Left Lower Extremity Arterial Duplex Sonogram, 9/24/07
Chronic Pain Management Program Notes, 8/18/08-8/22/08, 8/13/08-8/15/08, 8/7/08, 8/25/08
Clinic, 11/24/08

PATIENT CLINICAL HISTORY SUMMARY
Claimant is a male who was injured on xx/xx/xx while employed as a. He slipped and was hit on the left knee by a chain that was holding a crane. He underwent surgery on 12/21/2006 for left knee arthroscopic partial medial meniscectomy, left knee arthroscopic partial lateral meniscectomy , left arthroscopic partial synovectomy and left knee arthroscopic chondroplasty medial femoral condyle. He underwent a second surgical procedure on 3/27/2007. He was examined recently on 1/13/2009 by M.D. as a Designated Doctor Evaluation. The extent of his injury is described as: Medial and lateral meniscus tear, left knee; post traumatic arthritis, left knee and chronic synovitis, left knee. His current diagnoses are: medial and lateral meniscus tear, left knee, post traumatic arthritis left knee and chronic synovitis, left knee. He currently complains of pain, weakness and a stabbing sensation in the left knee. He rates pain at 7 at its best and 10 at its worst. Pain is consistent in nature and standing, sexual activity, bending, reaching, pushing, walking and anything that puts weight or pressure on his knee makes his pain worse. Massage, rest and medication make his pain better. He ambulated with a limp to the left side and utilized a cane. Ankle plantar flexion was normal. He was unable to perform the heel walk or toe walk. The patient was assessed by Dr. MD for a multi-disciplinary CPMP and felt that he would benefit from an additional 2 week program. A detailed treatment plan was written on 1/12/2009.

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

The insurance reviewer denied this request for the following reasons: “The plan does not focus on work hardening, which is not consistent with ODG criteria. There was scant information about the behavioral part of the program, no indication he has learned any behavioral pain control, not baseline and current objective psychological measures other than Beck inventories, and no return to work plan. The request does not meet ODG.”

Specifically, the examiner states the following criteria have not been met: An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement; the patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect his change; treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains; at the conclusion and subsequently, neither re-enrollment in nor repetition of the same of similar rehabilitation program is medically warranted for the same condition or injury.

The previous reviewers are correct that the request does not meet the criteria in the ODG Guidelines. Although there is a short individual treatment plan presented, it does not cover all of the points discussed in the ODG. This includes a discussion of why the previous program was or was not effective, a full multidisciplinary evaluation and documentation of the patient’s motivation. The guidelines have not been met. The reviewer finds that medical necessity does not exist for Continue with Chronic Pain Management times 10 sessions (5 sessions per week for 2 weeks) (97799).

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)