

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program for 10 sessions over five days a week for two weeks as an outpatient to the right knee

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

MD, Board certified Physical Medicine and Rehabilitation Physician

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

Official Disability Guidelines, Section: Pain

Notices of Denial, 5/10/10, 5/24/10

6/7/10, 4/27/10, 5/18/10

Pain Management 12/3/09

PATIENT CLINICAL HISTORY SUMMARY

This is a employee who fell coming down a 2-step ladder. She complains of right knee pain with radiation to the hip. She has end stage osteoarthritis based on the orthopedic evaluation. There are no MRIs to review. She has had Synvisc injections. Medications are partially effective in controlling the pain. She takes Ultracet and Celebrex. She had a partial menisectomy in 2001. The orthopedic review indicates that a total knee replacement would be curative in this instance.

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

Chronic pain programs are recommended where there is access to programs with proven successful outcomes. They are appropriate for patients with conditions that have resulted in delayed recovery. There should be a complete diagnostic assessment to determine all the components of the patient's pain. In this case an orthopedist has considered this case and indicates that the condition of the OA is advanced and will require a total knee replacement.

Therefore, as per the ODG, the chronic pain program is not indicated. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program for 10 sessions over five days a week for two weeks as an outpatient to the right knee.

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)