

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

chronic pain management program of five times a week for two weeks (80 hours at eight hours a day for 10 days) 97799 for the right knee and left hand

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

M.D., Board Certified Physical Medicine and Rehabilitation

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 and Treatment Guidelines
Notification of adverse determination 07/29/11
Notification of reconsideration determination 09/15/11
Request for review by IRO 10/24/11
Operative report right knee partial lateral meniscectomy and ACL reconstruction 01/27/11
Office notes Dr. 11/23/10-04/06/11
Request for preauthorization 07/21/11
Behavioral medicine evaluation 07/13/11
Physical assessment evaluation and treatment plan 07/21/11
Multidisciplinary chronic pain management physical therapy goals 07/21/11
Functional capacity evaluation 07/19/11
Office notes Dr. 09/08/10-10/14/11
Therapy daily progress notes 09/16/10-08/01/11
MRI right knee 09/28/10
EMG/NCV upper extremity 09/16/10
Physical assessment evaluation and treatment plan 09/09/10, 10/26/10, and 02/21/11
Physical performance evaluation 09/10/10, 10/28/10 and 06/15/11
Office note Dr. 11/04/10
X-ray left hand and wrist 11/04/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was injured when he slipped and fell from a retaining wall and tried to catch himself with his left hand. He underwent ORIF for metacarpal fracture of left hand on 08/20/10. He is status post right partial lateral meniscectomy and ACL reconstruction performed 01/27/11 followed by post surgical therapy.

His providing doctor has recommended he participate in a chronic pain management program.

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

It is not clear that this patient has exhausted lower levels of care and is an appropriate candidate for this program. His Beck scales remain exceedingly high despite a course of individual psychotherapy, which is noted to be a negative predictor of success. Maximized pharmacotherapy has not been substantiated with pain and symptom logs with medication use. The reviewer finds no medical necessity for chronic pain management program of five times a week for two weeks (80 hours at eight hours a day for 10 days) 97799 for the right knee and left hand.

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)