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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Program 10 days (80 hours)

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

Board Certified Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
MRI of right and left knee dated 12/14/09
Second opinion MRI of right and left knee dated 01/17/10
Clinical notes dated 05/12/10-05/21/12
Letter of medical necessity dated 06/13/12
Patient assessment request for 10 day functional restoration program dated 06/26/12
Psychosocial evaluation dated 06/26/12
Physical performance evaluation dated 06/26/12
Patient assessment request for extension 10 day functional restoration program dated 10/01/12
Physical performance evaluation dated 10/01/12
Utilization review determination dated 10/04/12
Appeal of denied 10 additional sessions dated 10/08/12
Appeal to IRO of denied 10 additional sessions dated 10/14/12
Patient assessment request for extension 10 day functional restoration program dated 10/14/12
Physical performance evaluation dated 10/14/12
Vocational training plan
Chronic pain program outcomes summary
Utilization review determination dated 11/01/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was walking down a ramp when her left knee bent all the way back. She tried to keep balance on her right leg/knee but then fell onto the ground hitting the floor with the right knee first and then the left. Treatment to date includes physical therapy, injections, medication management, and MRI scans. Psychosocial evaluation dated 06/26/12 indicates that FABQ-PA is 21 and FABQ-W is 39. BDI is 30 and BAI is 24. Diagnoses are chronic pain syndrome, depressive disorder and sleep disturbance. PPE dated 06/26/12 indicates that required PDL is medium. Patient assessment/request for extension 10 day functional restoration program dated 10/01/12 indicates that the patient is near completion of her previously approved set of 10 FRP/CPMP daily sessions. BDI improved from 32 to 14 and BAI from 24 to 12. Pain level has decreased from 8/10 to 4/10 with less medicine use on most days and with much fewer pain spikes. The patient continues to use OTC Advil and Tylenol on a prn basis. The patient has completed 160 hours of chronic pain management program to date.

Initial request for chronic pain program 10 days was non-certified on 10/04/12 noting that the guidelines state that total treatment duration should generally not exceed 160 hours for chronic pain management programs unless clear rationale for the specified extension and reasonable goals to be achieved are documented. It is noted that the BDI and BAI scores are in the mild category. There is no explanation provided as to why the current limitations in the range of motion cannot be addressed with a home exercise program. Comparison of the current PPE to the requirements of the claimant's normal work activities is not provided for evaluation of current functional deficit in regards to the required work duties. The denial was upheld on appeal dated 11/01/12 noting that the claimant has documented improvement with the 160 hours of chronic pain management provided thus far. The claimant's BDI has improved to 14 and BAI has improved to 12. Although this is not the treating physician's goals of BDI of 10 and BAI of 8, they are certainly both within the mild category. The guidelines would generally not exceed a 20 full day or 160 hour sessions unless a clear rationale for specific extension and reasonable goals to be achieved had been documented. The claimant has benefited with good narcotic reduction, currently taking over the counter anti-inflammatories. The knee functional range of motion and physical examination findings do not support further functional restoration. The claimant has documented functional range of motion of the left knee with improvement in both the BDI and BAI scores. There are no significant limitations in range of motion that could not be address with a home based exercise program at this time.

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

Based on the clinical information provided, the request for chronic pain program 10 days (80 hours) is not recommended as medically necessary, and the two previous denials are upheld. The patient has completed 160 hours of chronic pain management program to date. The Official Disability Guidelines note that treatment duration should generally not exceed 160 hours of chronic pain management program. There are no exceptional factors of delayed recovery documented to support exceeding this recommendation. The patient's Beck Depression Inventory and Beck Anxiety Inventory are currently in the mild range. The patient is not taking any narcotic or psychotropic medications and is managed on over the counter anti-inflammatories only. The patient presents with functional range of motion of the left knee, and there is no clear rationale provided as to why any remaining deficits cannot be addressed with an independent, self-directed home exercise program as recommended by the guidelines.

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)