

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/04/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5xwk x2wks

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

M.D., Board Certified Pain Medicine

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

ODG-TWC Treatment Guidelines

Utilization review determination dated 04/18/12, 05/09/12

Appeal letter dated 05/02/12

Office visit notes dated 04/10/12, 02/07/12, 12/05/11, 08/18/05, 09/06/05, 08/23/06, 02/12/07, 03/05/07, 04/16/07, 06/11/07, 07/25/07, 02/06/08, 03/19/08, 04/08/08, 06/23/08, 07/17/08, 09/25/08, 12/15/08, 01/20/09, 02/13/09, 02/18/09, 03/16/09, 03/25/09, 04/23/09, 04/29/09, 05/21/09, 06/19/09, 04/13/05, 05/16/05, 05/23/05, 06/16/05, 07/07/05, 07/22/09, 06/24/09, 08/18/09, 08/19/09, 09/15/09, 10/13/09, 11/11/09, 12/14/09, 02/10/10, 07/09/10, 08/09/10, 08/27/10, 09/08/10, 10/13/10, 11/16/10, 11/18/10, 12/01/10, 01/05/11, 01/26/11, 02/21/11, 03/23/11, 04/06/11, 05/03/11, 05/09/11, 06/01/11, 08/03/11, 10/03/11, 12/05/11, 02/07/12, 02/08/12, 04/10/12

IRO dated 09/29/10

Procedure report dated 01/25/07

Radiographic report dated 01/25/07, 02/13/09

Home health certification dated 02/09/07

Patient treatment goals and objectives dated 04/06/12

Initial diagnostic screening dated 05/02/12, 06/05/08, 03/29/12

PPE dated 03/01/12, 08/15/05, 05/23/07, 03/01/12

Handwritten notes dated 03/20/12, 02/21/12, 01/18/12, 07/13/05, 07/15/05, 07/18/05, 07/19/05, 07/21/05, 07/25/05, 07/26/05, 07/28/05, 08/01/05, 08/03/05, 09/01/05, 06/20/07, 06/21/07, 06/25/07, 06/27/07, 07/02/07, 07/03/07, 07/05/07, 07/12/07, 07/18/07, 07/19/07, 07/09/08, 09/25/08, 05/21/09, 03/30/05, 04/19/05, 04/26/05, 04/28/05, 04/29/05, 05/03/05, 05/04/05, 05/06/05, 05/11/05, 05/13/05, 05/17/05, 06/20/05, 06/21/05, 06/23/05, 06/29/05, 06/30/05, 07/05/05, 04/14/10, 05/25/10, 06/22/10, 07/07/10, 07/08/10, 08/04/10, 09/08/10, 10/13/10, 11/16/10, 12/15/10, 01/19/11, 02/22/11, 03/23/11, 05/04/11, 05/10/11, 06/01/11,

07/06/11, 09/14/11, 10/19/11, 11/2/11, 01/18/12, 02/21/12, 03/01/12, 03/20/12, 05/09/12
CT of right femur and right knee dated 02/28/11
PT exercise flow sheets
Bona fide job offer dated 04/18/05, 04/01/05

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. She slipped on relish and fell. She has had diagnostic testing, left knee meniscal repair on 10/28/05, right TKR in 1999, right TKR on 01/25/07, physical therapy, and medication management. PPE dated 03/01/12 indicates that required PDL is light and current PDL is sedentary light. Initial diagnostic screening dated 03/29/12 indicates that current medications include Pennsaid, Soma, Naproxen, Lyrica, Clyb/Metform, Avapro, Crestor, Dilantin, and Zetia.

Her BDI is 33 and BAI is 26. The diagnosis is pain disorder associated with work related injury medical condition and psychological factors; and depressive disorder, nos. Diagnostic screening dated 05/02/12 indicates that BDI is 33 and BAI is 26.

Initial request for chronic pain management program 5 x 2 wks was non-certified on 04/18/12. A note dated 04/10/12 from Dr. recommends the pain program, but also states that she had a surgical examination with Dr. who reported that 'once the right knee is strengthened most likely she will need another surgical intervention'. Therefore, the submitted documentation states that further surgery will most likely be indicated. It is unclear why she has not been given at least a home exercise program to work on strengthening her knee and why it is stated in the report that all care had been exhausted. The denial was upheld on appeal dated 05/09/12. This is a seven year-old claim with a knee injury resulting in a fracture, which complicated a total knee arthroplasty. The issue of further surgery has been previously raised, but eliminated to the reviewer's satisfaction. The patient is collecting SSDI and wishes to supplement her income with customer service/seated type work. Given the anticipated work plan and the medical unlikelihood that the individual will ever be able to perform any work beyond the seated level, medical necessity is not established for a program of this magnitude, and it is unlikely that any significant improvement in function would be possible.

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

The patient's date of injury is greater than seven years old. The Official Disability Guidelines do not support chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. Given the extent of the patient's injury, it is unlikely that she will ever be able to perform any work beyond the seated level, as noted by the previous reviewer. The reviewer agrees with previous reviewer that a chronic pain management program is not likely to provide significant benefit to this patient. The reviewer finds that there is no medical necessity for Chronic Pain Management Program 5xwk x2wks.

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)