

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Oct/26/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 80 hrs chronic pain management for right knee

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for 80 hours chronic pain management for right knee is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. The patient fell with her body twisted. She reports that she tore her meniscus and felt immediate pain. The patient underwent right knee arthroscopy on xxxx, synovectomy and arthroplasty on xxxx, osteochondral graft on xxxx, right knee unicompartmental arthroplasty on xxxx, total knee replacement surgery on xxxx and right knee arthroplasty revision surgery on xxxx. Functional capacity evaluation dated xxxx indicates that current PDL is sedentary and required PDL is medium. Initial diagnostic interview dated xxx indicates that treatment to date includes diagnostic testing, physical therapy, aquatic therapy, individual psychotherapy, bracing, nerve blocks, epidural steroid injections, medication management, and multiple surgeries to the right knee, most recently on xxxx (right knee total knee revision). Current medications are Norco, Lidoderm patches, Cymbalta and Ambien. BAI is 14 and BDI is 15. Diagnoses are mood disorder, pain disorder associated with both psychological factors and a general medical condition.

Initial request for 80 hours of chronic pain management was non-certified on xxxx noting that the patient has already participated in physical therapy, aquatic therapy, individual psychotherapy and medication management without significant improvement. As such, it is unclear how further participation in this regard would be of benefit. Moreover, the patient has already participated in a work hardening program and the guidelines state that at the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The records do not establish that potential negative predictors of efficacy have been addressed in this patient. Appeal letter dated xxxx indicates that the patient participated in a work conditioning program in xxxx. She attempted to return to her same employer, but was terminated. The patient also attempted to return to work in xxxxx, but was unable to handle expected work duties. The denial was upheld on appeal dated xxxx noting that there was no clear evidence of significant objective functional deficits to warrant treatment with a functional restoration

program. As the date of injury was XX/XX/XX, there is no new injury to warrant the need of a functional restoration program at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XXXX and has undergone extensive treatment including several surgeries to the right knee. However, there is no documentation of any recent active treatment. The patient's date of injury XX/XX/XX. The Official Disability Guidelines note that if a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. The submitted records report that the patient has unsuccessfully attempted to return to work on at least two prior occasions. Given the lack of significant improvement with extensive treatment completed to date with a current physical demand level of only sedentary, it is unclear why significant improvement is expected with a chronic pain management program. As such, it is the opinion of the reviewer that the request for 80 hours chronic pain management for right knee is not recommended as medically necessary and the prior denials are upheld.

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)