MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

AMENDED Notice of Independent Review Decision

DATE OF REVIEW: 5/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Preauthorization for 20 days of pain management program (5x/wk x 4 wks).

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

This case was reviewed by a board certified psychiatrist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

Primary Dx Code	*Service Being Denied*	*Units*	*Type Review*	*DOS*	*Amt Billed*	*Date of Injury*	*DWC Claim #*	*Uphold / Overturned*
845.09	97799	20	Prospective			xx/xx/xx	xxxxxxxxxx	Uphold

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 4/25/07
2. Determination Notices – 2/28/07, 3/12/07
3. Records and Correspondence – 2/7/07-3/6/07

PATIENT CLINICAL HISTORY:

This case concerns a male who sustained a work related injury on xx/xx/xx. Records indicated that while exiting an excavator, he missed a step and fell off the machine. These records also noted he landed on his right foot and immediately felt pain in his right heel. Diagnoses have included chronic ankle pain and major depression. Evaluation and treatment for this injury has included steroid injections, medications, aquatic therapy, group therapy, and physical therapy.

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

Details of the patient's past history are lacking from the records. The patient shows no evidence of significant psychological compromise and he has had no previous psychological intervention although he is on Lexapro. The patient has also been treated with physical therapy, steroid injections, aquatic therapy and electrical stimulation, but there are no details regarding these interventions and their effects. Thus the data reviewed failed to demonstrate that the patient has failed conservative management. As such, the Official Disability Guidelines (ODG) criteria were not met. Therefore, preauthorization for 20 days of pain management program (5x/wk x 4 wks) is not medically necessary for the patient at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN 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)**