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Notice of Independent Review Decision

DATE OF REVIEW: 5/25/12

IRO CASE: #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic Pain Management/Initial 80 hrs. outpatient (CPT 97799)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board certified in **Anesthesiology and Pain Management**

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld **(Agree)**
Overturned (Disagree)
Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 5/04/12, 4/10/12
Request/Reconsideration Pain Program, Injury 1 4/19/12 & 4/05/12
Clinic Notes, Dr. & Dr. 3/28/12, 2/15/12, 2/02/12
Psychological Assessment Rpt, Dr. PsyD, 3/09/12
Assessment/Pain Mgmt & Behavioral Medicine, DO OC, 2/02/12, 7/21/11
Physical Performance Eval, Center –1/25/12
ODG

PATIENT CLINICAL HISTORY [SUMMARY]

Patient is a female who sustained a knee injury in xx/xx while performing her customary duties as a xx. She was walking up the stairs and slipped due to damp conditions on the stairs. She twisted her knee while grabbing at the railing for support. Patient has completed 10 days of work hardening. She also received a cortisone injection which did not help; an additional injection was requested, by denied. Patient states pain level with medication as 4/10; pain level without medication as 6/10. Her medications include Mobic, Omeprazole and Flexeril. After failure of conservative care and surgery performed in 5/10 (no surgical data provided), the pain persists. Patient's

treating physician referred her for a psychological assessment (3/09/12) during which depression and anxiety were diagnosed.

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

I agree with the denial of the benefit company. Rationale: There are other options likely to result in significant clinical improvement that could be performed at a lower acuity level. There's no indication that antidepressant therapy has been utilized and an aggressive trial of antidepressants could be instituted prior to considering a behavioral pain management program. Rationale was based on ODG Guidelines.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**