True Decisions Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: manager@truedecisionsiro.com

Date: 12/4/2018 11:07:42 AM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program XX X week X XX weeks or XX days/XX hours

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

REVIEW OUTCOME:

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

☒ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX who was diagnosed with other internal XX of the XX knee and other tear of XX XX, current injury, XX knee, subsequent encounter. XXXX. On XXXX for moderate-to-severe and constant XX XX pain. The pain had been increasing with physical therapy. XXXX felt XX about XX XX to work due to the moderate-to-severe pain to the XX knee. XXXX also reported XX XX not being able to go back to work. Examination of the XX knee showed mild-to-moderate XX to palpation to the XX joint line. There was XX of the XX thigh. The gait was XX. XXXX exhibited signs of XX XX XX. XXXX had a functional capacity evaluation on XXXX. XXXX was referred to determine XXXX functional abilities and physical demand characteristics of work level. XXXX current physical demand capacity level was sedentary while XXXX required physical demand capacity level was heavy. XXXX could not perform the physical demand levels of XXXX usual and customary position. During inspection, XXXX XX with abnormal gait-toe out flare, began to XX with prolonged walking. There was a XX-point XX present to XXXX XX knee area. Range of motion of the XX knee was reduced in flexion. Muscle testing of the XX XX revealed pain to XXXX XX XX area with flexion and adduction. Palpation of the XX general XX joint line revealed XX of both the joint lines. XX and XX stress increased the knee pain. Over the material handling and non-material handling tests, XXXX did XX XX all parts of the evaluation due to the perception of increased dull and sharp XX XX pain. The XX knee pain also XX to

XXXX XX XX area. Symptom magnification testing was XX for only XX XX and regional disturbances. On XXXX had a Pain Management Program Behavioral Health Assessment performed by XXXX. XXXX presented with a XX XX and a XX XX during the interview. XXXX exhibited XX XX, stated XXXX had been undergoing XX XX of XX due to XX of XX XX and difficulty XX. XXXX demonstrated XX-XX thoughts about XXXX and XXXX future. XXXX demonstrated XX XX when completing necessary paperwork for the interview. XXXX experienced increased levels of XX XX also due to XXXX lack of XX. XXXX used to be the XX of the household, but now struggled to XX XXXX. XXXX was worried that if XXXX could not XX XX and XX XX, then XXXX would XX XXXX job, thus adding to XXXX XX XX. XXXX was concerned that XXXX did not have XX XX to XX or XX for XXXX. XXXX physical limitations XX XX XXXX XX to XX XX of XX XX such as XX, XX, XX, XX, XX, XX. In regard to XXXX return to work, XXXX was XX XX due to XXXX XX to perform XX XX job functions XX, XX, and XX because of XXXX pain and discomfort. XXXX reported XXXX XX XX XX XX XX or XX duty work. XXXX XX XX Inventory-II score was XXXX indicating XX XX and XX XX Inventory score was XXXX indicating XX XX. Treatment to date included medications (helped to relieve pain), XX hours of work conditioning, physical therapy (pain increased), surgical intervention (XX XX arthroscopy partial XX XX, XX on XXXX) and off-work status for XX weeks. XXXX had participated in XX levels of care for a period of XX months with minimal improvement, participated in XX approved sessions of passive modalities like electromagnetic stimulation, heating pads, and ice packs, participated in XX approved sessions of physical therapy, participated in XX surgical procedure to XXXX XX knee region, participated in XX hours of work conditioning, participated in a home exercise regimen for a period of XX months all with minimal reported improvement in pain and functioning. XXXX had also participated in medication therapy for a period of XX months, with minimal to no reported improvement to pain or functioning. Per a utilization review determination letter dated XXXX, the request for XX pain rehabilitation program was denied. Rationale: "Regarding the request for chronic pain management program, the Official Disability Guidelines, Pain Chapter Predictors of Success and Failure include: XX. As such, medical necessity is not established for a chronic pain management program (XX) or XX days/XX hours." A letter dated XXXX indicated that the appeal for chronic pain management program or XX days / XX hours chronic pain program was not recommended as medically necessary. The initial request was non-certified noting that the Official Disability Guideline Pain Chapter XX. XXXX did not have a job to return to (per XXXX exam note) and XXXX had a XX XXXX. XXXX also had physical examination findings that did not appear to be addressed in that XXXX had knee instability. As such, medical necessity was not established for a chronic pain management program, XX times per week for XX weeks) or XX days / XX hours. There was insufficient information to support a change in determination, and the previous non-certification was upheld.

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

The patient meets ODG criteria for the general use of multidisciplinary pain management program. The patient was adequately evaluated and has XX resulting from chronic pain. XXXX is currently not a candidate for surgery. XXXX is motivated for change. XXXX has exhausted primary and secondary level of pain management without much success. There is enough evidence in medical literature to support that Chronic Pain Management, which comprises of XX

behavior therapy, biofeedback, stress management, XX, XX skill training, and relaxation training, is an effective method of managing pain.

Given the documentation available, the requested service(s) is considered medically necessary and the request is overturned.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Pain (updated 7/10/2018)- Chronic pain programs (functional restoration programs) Criteria for the general use of multidisciplinary pain management programs