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**Notice of Independent Review Decision
Notice of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: August 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A female patient has requested coverage 10 sessions of a chronic pain management program for treatment of the patient's neck and right shoulder pain.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overtuned (Disagree)
 Partially Overtuned (Agree in part/Disagree in part)

I have determined that 10 sessions of a chronic pain management program are medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/1/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Medical Review Organization (IRO) dated 7/13/10.
3. TDI Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 7/14/10.
4. TDI Notice to IRO of Case Assignment dated 7/14/10.
5. Letter from Rehabilitation Center dated 6/9/10.
6. Pre-Certification Request from ED.D., Psych dated 5/19/10.
7. Medical records from Clinic Inc. dated 8/27/09, 8/28/09, 9/2/09, 10/15/09, 11/3/09, 11/11/09, 11/13/09, 11/16/09, 11/24/09, 12/8/09, 12/22/09, 1/19/10, 2/16/10, 3/16/10, 4/13/10, 4/16/10, 4/27/10, 5/11/10, 5/17/10, 5/25/10, 6/8/10 and 7/6/10.
8. Functional Capacity Evaluation Summary completed by DC dated 9/2/09, 10/15/09, 11/16/09, 4/16/10 and 5/17/10.
9. Daily Progress & Therapy Notes dated 10/23/09, 10/29/09, 10/30/09, 11/2/09, 11/4/09, 11/6/09, 11/9/09, 11/11/09, 11/18/09 and 11/20/09.

10. Battery for Health Improvement 2 (BHI2) dated 4/16/10.
11. Work Hardening Treatment Plan dated 5/6/10 through 6/2/10.
12. Initial consultation performed by MD dated 1/22/10.
13. Texas Department of Insurance (TDI), Division of Workers Compensation (DWC) Assigned Designated Doctor's Evaluation and Report dated 2/4/10.
14. Denial documentation dated 5/26/10 and 6/23/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

A female patient sustained an on-the-job injury on xx/xx/xx. The patient's provider indicates that the patient was. On 9/21/09, a right shoulder MRI noted a mild degree of fluid distention of the subdeltoid, subacromial bursa or traumatic bursitis without tears in the rotator cuff. On exam on 9/29/09, the provider noted that the patient presented with sharp, sticking cervical pain which radiated into her right shoulder and right upper extremity with dysesthesias at her arm and weakness of the right arm. The patient also reported headaches, which radiate occipitofrontally and difficulty sleeping. She has a cervical MRI on 10/8/09 which identified "straightening of cervical lordosis, C4-5 and C5-6 2-3 mm focal right paracentral disc protrusion which indents the spinal cord." On 10/20/09, an upper extremity EMG/NCS identified "severe bilateral carpal tunnel syndrome." The provider assessed the patient with cervical sprain/strain; cervical intervertebral disc disease; right shoulder sprain/strain with impingement; rule out supraspinatus tendonitis versus bursitis; and cervicogenic headache. Medications were prescribed including Darvocet-N, Flexeril and Medrol Dosepak. The patient underwent physical therapy. She had a cervical ESI on 3/24/10 and experienced 30-40% reduction in pain. On 6/8/10, it was noted that the patient reported her neck and right shoulder pain as 6 on a scale of 10 off medications, and 2 to 3 on a scale of 10 on medications. An earlier functional capacity evaluation noted that the patient was not able to perform the physical level of work needed to return to her former job. In May 2010, the patient was referred to a work hardening/work conditioning program to improve strength, endurance, and tolerance to work related positioning and activities. The patient received 10 sessions of the work hardening program. On 5/17/10, the patient underwent another functional capacity evaluation which found that the patient had exhausted all lower level modalities and remained unable to effectively deal with her chronic pain. The evaluating consultant recommended 10 sessions of a chronic pain management program. The Carrier has denied this request indicating that the disputed services are not medically necessary for treatment of the patient's neck and right shoulder pain.

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

Upon review of the medical records provided, this patient meets Official Disability Guidelines (ODG) criteria for participation in a chronic pain management program as evidenced by the following. The patient has been treated conservatively for more than six months. She has not responded to previous medical care. There does not appear to be the potential for medical intervention to provide significant relief. She has not been able to return to her former level of function. The patient's pain has continued well beyond expected tissue healing time. Pain

continues to interfere with the patient's physical, psychological, social and vocational functioning. Based on these factors, the requested 10 days of participation in a chronic pain program is medically necessary to assist the patient in regaining function.

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)