

MAXIMUS Federal Services, Inc.
11000 Olson Drive, Suite 200
Rancho Cordova, CA 95670
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

Notice of Independent Review Decision

MAXIMUS Federal Services, Inc.

11000 Olson Drive, Suite 200
Rancho Cordova, CA 95670
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 10, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of a chronic pain management program.

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)
- Overturned (Disagree)**
- Partially Overturned (Agree in part/Disagree in part)

The requested service, 10 sessions of a chronic pain management program, is 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 11/19/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/22/10.
3. TDI Notice to IRO of Case Assignment dated 11/22/10.
4. Pre-Authorization Requests dated 10/4/10 and 10/28/10.
5. Medical records from Rehabilitation dated 1/5/10, 7/21/10, 9/15/10 and 10/22/10.
6. Texas Workers' Compensation Work Status Report dated 9/13/10.
7. Medical records from Medical Centers dated 9/13/10.
8. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. An MRI performed in January 2009 revealed a 2mm paracentral disc bulge at L5-S1 with lateral extension causing minimal narrowing of the lateral recess on the right. EMG/NCV performed in March 2009 revealed bilateral sacroiliac nerve root irritation. The patient was assessed with sprain/strain of the lumbar region. The patient has a history of low back and right lower extremity (RLE) pain complaints following a slip and fall injury. The patient has received conservative care and lumbar facet blocks. The patient also received 10 sessions of physical therapy between February and March 2009. On 10/22/10, the patient underwent a psychological diagnostic interview. The examining provider noted that although the patient has made significant progress physically, she has reported an increase in her pain symptoms and levels of interference. The patient expressed symptoms of depression and anxiety during the interview. The provider indicates that participation in an interdisciplinary pain management program will allow the patient to continue improving physically, while educating her on how to manage her pain. As such, 10 sessions of a chronic pain management program have been requested. The Carrier indicates the requested service is not medically necessary. According to the review performed by the Carrier, the patient does not meet current guidelines for participation in a chronic pain management program.

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

I have determined that the requested 10 sessions of a chronic pain management program are medically necessary for this patient. Based upon the information provided, this patient meets Official Disability Guidelines (ODG) for use of a multidisciplinary pain management program. Consistent with ODG guidelines, the patient has a chronic pain syndrome, with evidence of loss of function that has persisted beyond three months. In addition, there is evidence of secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain. She has been unable to restore pre-injury function after a period of disability such that her physical

capacity is insufficient to pursue work needs. There is also evidence of the development of psychosocial sequelae (i.e., anxiety and depression) that limits function or recovery after the initial incident; these issues have a reasonable probability to respond to treatment intervention. Further, the records demonstrate that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Moreover, the documentation demonstrates the patient has had an adequate and thorough multidisciplinary evaluation per ODG guidelines.

All told, the submitted evidence establishes that this patient meets accepted guidelines for participation in a chronic pain management program. Therefore, the requested service is medically necessary for this patient.

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)