

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: April 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

An additional 10 days of a chronic pain management program (CPMC), 97799.

**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:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested service, an additional 10 days of a chronic pain management program (CPMC), 97799, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient is a male who sustained a work related injury to his right elbow on xx/xx/xx while in the process of lifting a 40-foot tube of steel, weighing approximately 70 pounds. The patient noted that he heard an audible pop in his right elbow and then developed an acute onset of right elbow pain. The patient was diagnosed with a right elbow and forearm sprain and referred to an orthopedic surgeon. By report, an MRI scan performed on 6/4/08 revealed a partial tear of the patient's bicep. It is further noted that a repeat MRI scan on 8/21/08 demonstrated a longitudinal split involving the partial thickness of the biceps tendon and was suggestive of a small osteochondral abnormality. The patient underwent surgery on 7/28/09 to debride and release the common extensor tendon. On 4/2/10, the patient underwent right shoulder surgery to correct his subacromial bursitis, acromioclavicular joint arthropathy and a rotator cuff tear. The patient has undergone physical therapy with little/no relief of his pain symptoms. He rates his pain level as 7 out of 10. He has completed 20 days of a pain management program. A report from the pain management program dated 2/7/11 indicates that despite the intensive nature of the program and increasing his functional tolerances, the patient notes that he has maintained his pain level. The provider indicated that the patient requires an additional 10 days of an interdisciplinary pain rehabilitation program in order to extinguish active symptoms over a long term basis, maximize his functional tolerances and propel him towards a safe return to work.

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

Upon review of the records provided, there is insufficient evidence of benefit from the patient's previous participation in a chronic pain management program to support the request for an additional 10 days of pain management program services. Specifically, no improvement in the patient's pain level was documented. The submitted records do not demonstrate there has been a decrease in the use of pain medications or a decrease in the patient's subjective complaints. The Official Disability Guidelines (ODG) indicate that total treatment of chronic pain programs should not exceed 20 days. According to ODG guidelines, treatment duration in excess of 20 days requires a clear rationale for the specified extension and reasonable goals to be achieved. Given the lack of improvement from the patient's initial participation in the pain management program, there is insufficient rationale to support the requested service. As such, 10 additional days of a chronic pain management program (CPMC), 97799 are not medically necessary for treatment of the patient's condition.

**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)