

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: August 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5 x 2 (10 sessions).

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

M.D., Board Certified in Occupational Medicine.

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, chronic pain management program 5 x 2 (10 sessions), is not 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 8/2/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/8/11.
3. Notice of Assignment of Independent Review Organization dated 8/8/11.
4. Medical records from multiple providers from the period of 8/4/08 through 6/24/11 (approximately 1100 pages).
5. Letter from DO dated 7/11/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient is a male who sustained an injury on xx/xx/xx when he was employed as a and injured his back setting up a banquet. A CT scan of the lumbar spine performed on 8/4/08 showed large right paracentral disc herniation at L5-S1 with contact and posterior displacement of the traversing right SI nerve root and probable chronic pars interarticularis fracture at L5. The patient was deemed to be at Maximum Medical Improvement (MMI) with a 5% Impairment Rating. The patient is status post two level L4 through S1 fusion on 6/11/10. On 6/24/11, it was noted the patient had completed 20 sessions of a chronic pain management program. He continued to report sharp low back pain, radiating laterally and posterolaterally into his left leg. Severe dysesthesias at his right leg was noted. At that time, the patient's medications included hydrocodone and Neurontin. EMG/NCV studies of the lower extremities performed on 6/20/11 were read as normal. The patient was assessed with failed back surgery syndrome; status post two-level L4 through SI fusion. The patient's provider indicated the patient had little improvement in his physical demand level (PDL) following work hardening and a chronic pain program. The patient has +1 reflexes and the absence of atrophy at his lower extremities. The provider has requested an additional 10 sessions of a chronic pain management program for the purpose of medication reduction.

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

Upon review of the submitted documentation, I have determined that the requested service is not medically necessary. Based on the medical records provided, this patient has undergone extensive postoperative treatment and pain management. He has not shown improvement with this type of therapy. The patient has already received 20 sessions of a chronic pain management program and has exceeded Official Disability Guidelines (ODG) recommendations for therapy for pain management in lumbosacral conditions including interbody fusion. Moreover, the patient has shown pain behavior. Thus, further participation in a chronic pain management program is not consistent with ODG criteria, is not medically necessary, and may further delay the patient's return to 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)