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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: June 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten (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

An 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)

I have determined that the requested service, ten (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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose treating providers have requested authorization for ten (10) sessions of a chronic pain management program. A review of the record indicates the patient sustained an injury on x/xx/xx when he was involved in a motor vehicle accident. Following the accident, the patient was assessed with cervical signs and symptoms, cervical radiculitis rule out herniated nucleus pulposus, shoulder signs and symptoms, rule out derangement, and myofascial pain. An MRI of the cervical spine showed multilevel mid cervical spondylosis changes at C4-6 with associated central and foraminal stenosis; left foraminal stenosis and left paracentral disc herniation or more focal bulge at C5-6 which could affect the left C6 nerve root; and flattening of the cervical spinal cord at C4-5 and C5-6 with evidence of myelomalacia at C5-6. In April 2011, the patient's provider indicated the patient was referred for initial/limited diagnostic screening for duration of physical problems and depression related to the patient's affect. Based on the results of the evaluation, it was recommended the patient participate in ten (10) sessions of a chronic pain management program. The URA has denied authorization for this service indicating that it is not medically necessary for the patient.

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

Review of the submitted information demonstrates that the patient meets Official Disability Guidelines (ODG) criteria for participation in a chronic pain management program. The records document that the patient participated in physical therapy but felt he was getting worse. There is also evidence of an MRI study that identified objective findings that support the patient's complaints. He has been seen by two pain specialists and has been on both narcotic and non-narcotic pain medications. He had a recent functional capacity evaluation that indicated he was not able to return to his prior level of physical demand activity. In addition, he has had psychological testing that identified an emotional component to his unresolved injuries. Furthermore, sufficient time has elapsed to allow healing and no other medical interventions are planned that would alter his function. All told, the submitted documentation demonstrates the patient meets ODG recommendations for participation in a chronic pain management program, and 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)**