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

Reviewer's Report

DATE OF REVIEW: March 18, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program services 5x/week for 2 weeks.

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)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested service, chronic pain management program services 5x/week for 2 weeks, 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 2/16/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/2/11.
3. Notice of Assignment of Independent Review Organization dated 3/22/11.

4. Medical record from MD dated 11/7/01.
5. Medical records from MD dated 6/2/09 and 6/29/09.
6. Pre-certification and Appeal Letters from Clinic dated 1/6/11 and 1/21/11.
7. Medical records from MD dated 7/8/10, 8/5/10, 9/2/10, 9/30/10, 10/28/10, 11/29/10, 12/27/10 and 2/21/11.
8. Medical record from MA, LPC dated 12/31/10.
9. Medical record from MD dated 1/20/11.
10. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an on the job injury while bending over a valve on xx/xx/xx. The patient is status post lumbar spinal cord stimulator implantation installed on 7/15/10 following an L4-5 fusion with repeat surgical intervention at the L2 and L3 levels consisting of a laminectomy and foraminectomy. Since this surgery, the patient continues to rate his pain as 7 on a scale of 10 off medications and 4 to 5 on medications. The patient is currently taking OxyContin for pain management. The psychological evaluation dated 12/31/10 indicates a diagnosis of chronic pain disorder associated with both psychological features and general medical condition. The evaluator identified the following problem areas: chronic pain syndrome; difficulty dealing with negative emotions appropriately; distorted beliefs about the relationship between pain and disability, which can lead to withdrawal from normal and productive activities; inadequate coping skills to manage emotional stress related to his work-related injury; lifestyle which has resulted in physical de-conditioning and loss of function; significant period of disability; symptoms of depression/anxiety; and an inability to return to work due to above problems. It was also recommended that the patient enter into an interdisciplinary chronic pain management program. A functional capacity exam was performed on 12/31/10 and indicated that the patient shows moderate signs of decreased functional ability. The patient's provider has requested authorization for a chronic pain management program, five days a week for two weeks.

The URA indicates the requested services are not medically necessary for treatment of the patient's medical condition. Specifically, the URA states that although the patient appears to satisfy most of the criteria for a chronic pain management program, the submitted clinical documentation does not include objective evidence that previous methods of treating the patient's chronic pain have been unsuccessful. The URA additionally states that the injury was more than 24 months ago and there are limited evidenced-based studies that strongly suggest that chronic pain management programs can provide return to work beyond this period.

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

Review of the submitted documentation demonstrates that the requested service, chronic pain management program services 5x/week for 2 weeks, is medically necessary for this patient. The patient meets the criteria established by the Official Disability Guidelines (ODG) for participation in a chronic pain management program. Consistent with ODG criteria, 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. He has been unable to restore pre-injury function after a period of disability such that his physical capacity is insufficient to pursue work needs. There is also evidence of the development of psychosocial sequelae (i.e., depression and anxiety) 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.

In light of the above, I have determined that the requested participation in a chronic pain program for 5x/week for 2 weeks 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

[**X**] 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)