

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: May 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program x 80 hours (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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The requested service, chronic pain management program x 80 hours (97799), is medically necessary for the patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 5/5/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) undated.
3. Notice of Assignment of Independent Review Organization dated 5/9/11.
4. Letters from Ph.D. dated 4/12/11 and 4/20/11.
5. Behavioral Health Assessment from Pain Recovery Center dated 3/30/11.
6. Consultation from Pain Recovery Center dated 3/30/11.
7. Functional Capacity Evaluation from Pain Recovery Center dated 3/30/11.
8. Treatment Plan from Pain Recovery Center undated.
9. Case Summary from Pain Recovery Center dated 4/11/11.
10. Consultation report from Center for Spinal Disorders dated 7/5/10.
11. New Patient Workman's Comp Visit from Invasive Spine Institute dated 1/21/11.
12. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates that the patient is a female who sustained a work injury on xx/xx/xx when she twisted her back while carrying a ladder. She complained of low back pain that radiated into her left leg. In spite of conservative treatment including anti-inflammatory medication, muscle relaxants, narcotic pain medications, physical therapy, restrictions of strenuous work activity and sacroiliac joint injection, she continued to have pain at 80% of her original pain level. X-rays of the lumbar spine, sacrum, coccyx and left hip were reported as normal. A CT scan of the abdomen and pelvis was reported as normal. MRI of the lumbar spine and pelvis did not identify any musculoskeletal abnormalities. A functional capacity evaluation performed on 3/30/11 indicated that the patient complained of sharp pain in the lower back radiating down the hip and her left leg. The evaluator noted the patient's pain was made worse with prolonged walking, bending and overhead reaching and was made better with sitting down on the right side. The patient rated her pain within the previous 30 days as 8 out of 10 at worst and 6 out of 10 at best. On 4/11/11, the patient's provider noted that the patient had completed a series of biofeedback/relaxation training and individual counseling sessions. According to the provider, the patient continues to report significant levels of pain and physical impairment and continues to report sleep disturbance, fatigue, irritability, anxiety and depression. A request has been made for chronic pain management program x 80 hours (97799).

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

Upon review of the submitted documentation, this patient qualifies for participation in a chronic pain management program based on Official Disability Guidelines (ODG) recommendations. Her response to treatment falls outside of the established norms without a specific physical

explanation for her symptom severity. She exhibits excessive pain complaints in relation to her diagnosis. She is not a candidate for surgery. The patient has experienced disability affecting her ability to return to normal work activity; she has been on light duty since her injury and is still having the same level of pain at the level of work she is performing.

All told, the presence of the above findings is consistent with ODG recommendations for chronic pain management. Therefore, the requested service, chronic pain management program x 80 hours (97799), is supported by ODG and is medically necessary to assist this patient to return to a higher level of 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)