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Notice of Independent Review Decision

DATE OF REVIEW: September 9, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Interdisciplinary pain rehabilitation program 5 times x 2 weeks (97799) - lumbar and right shoulder.

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, interdisciplinary pain rehabilitation program 5 times x 2 weeks (97799) - lumbar and right shoulder, 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 8/18/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/22/11.
3. Notice of Assignment of Independent Review Organization dated 8/22/11.
4. Medical records from Pain Center dated 12/10/10, 4/22/11, and 6/30/11.
5. MRI of right shoulder dated 12/17/10.

6. MRI of lumbar spine without and with contrast dated 12/17/10.
7. Physical Therapy Evaluation from Rehabilitation Services dated 12/14/10.
8. Visit note from Institute dated 4/22/11.
9. Request for Services from Pain Center dated 7/11/11.
10. Appeal for Services from Pain Center dated 7/21/11.
11. Letters from Dr. dated 5/23/11 and 7/14/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose provider has requested authorization for an interdisciplinary pain rehabilitation program 5 times x 2 weeks (97799) - lumbar and right shoulder. The patient sustained a work injury on xx/xx/xxxx while performing her duties. The patient reports that she slipped and fell landing on her back and that she heard a popping sound in her shoulder. An MRI of the right shoulder revealed no evidence of injury to the rotator cuff and a small joint effusion. An MRI of the lumbar spine revealed grade 1 spondylolisthesis at L5-S1 and bulging disc with annular tear at L4-5. The patient's provider indicates the patient continues to demonstrate and report limited physical and daily activity functioning. The provider states that previous treatments for chronic pain have been exhausted and have failed to improve her level of functioning. The patient has also been assessed with depression. Her provider has recommended participation in an interdisciplinary pain rehabilitation program 5 times a week for 2 weeks. The URA indicates there are no objective measures to validate that active rehabilitative effort has been exhausted and results of electrodiagnostic study have not been provided for review.

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

Upon review of the submitted documentation the requested interdisciplinary pain rehabilitation program is not medically necessary for treatment of this patient's condition. The records provided do not document in detail the conservative therapy that has been attempted by the patient. According to Official Disability Guidelines (ODG), there must be evidence that previous methods of treating chronic pain have been unsuccessful and an absence of other options likely to result in significant clinical improvement. The documentation provided does not demonstrate that these criteria have been met. There is no evidence the patient has undergone lumbar epidural steroid injections for her back pain. Nor is there evidence of an orthopedic consult for her shoulder or a spine specialist consult for her lumbar spine injury. As such, the documentation provided does not demonstrate that the requested interdisciplinary pain rehabilitation program 5 times x 2 weeks (97799) 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)