

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: March 27, 2012

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 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 Chronic Pain Management Program x 80 hours (97799) 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 3/7/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/6/12.
3. Notice of Assignment of Independent Review Organization dated 3/7/12.
4. Preauthorization Request dated 2/15/12.
5. Behavioral Health notes dated 2/15/12, 1/19/12, 1/16/12, 12/21/11, 11/17/11, 11/9/11, and 11/2/11.
6. Clinic notes from MD dated 1/17/12, 12/6/11, 11/8/11, 10/21/11, 8/19/11, 7/1/11, 5/31/11, 5/23/11, 4/11/11, 3/14/11, and 6/18/10.
7. Physical Performance Exam CPM dated 2/9/12.
8. Letter from LPC, and, LMSW, dated 9/12/11.
9. Clinic notes from, LPC, and , LMSW, dated 8/30/11.
10. Reconsideration Request: Chronic Pain Management Preauthorization Request dated 2/22/12.
11. Undated Letter of Medical Necessity from DC.
12. Request for Authorization dated 2/22/12.
13. Chronic Pain Program Progress Chart dated 2/22/12.
14. Pre-op assessment dated 10/21/11.
15. Mid-cities imaging MRI of Lumbar Spine without Contrast dated 4/12/11.
16. Letter of Medical Necessity dated 6/8/11.
17. Clinic notes from MD dated 4/11/11, 1/17/11, and 12/1/10.
18. Physical Performance Baseline dated 2/21/11.
19. Millennium Laboratories results dated 2/25/11.
20. Physical Performance Exam II dated 4/7/11 and 6/19/10.
21. BTE Progress Reports dated 6/19/10, 4/12/11, and 8/11/11-9/13/11.
22. Prescription for Evaluation and Treatment for Epidural Steroid Injection dated 4/29/11.
23. Clinic note from P.A. dated 4/29/11.
24. Imaging Center evaluation dated 5/10/11.
25. Institute of Pain Management procedure notes dated 7/29/11 and 6/17/11.
26. Testing Electrodiagnostic Results dated 7/6/11.
27. Physical Performance Exam WC dated 9/1/11 and 8/11/11.
28. Work Conditioning Progress Report dated 10/21/11, 10/6/11, 8/26/11, and 8/8/11.
29. Initial Treatment Plan dated 8/30/11.
30. Texas Workers' Compensation Work Status Report dated 10/5/11.
31. M.Ed., notes dated 12/21/11, 11/17/11, and 11/9/11.
32. Employers First Report of Injury or Illness dated xx/xx/xx.
33. Imaging from Hospital dated 7/30/10 and 6/21/10.
34. Clinic notes from MD dated 10/12/10.
35. Initial Assessment Form from DRMC Campus dated 11/10/10.
36. Undated letter from Pain Management and Physical Medicine provider.

37. Clinic notes from DO dated 12/31/10.

38. Denial documentation dated 2/29/12, 2/20/12, 1/3/12, 9/21/11, 9/7/11, and 3/9/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured on xx/xx/xx. The mechanism of injury was that the patient was lifting a gate at her place of employment. The patient states that at the time of her injury she heard a pop in her lower back. X-rays taken on 6/21/10 revealed no compression fracture, but did show straightening of the mid-thoracic lordosis and minimal sigmoid scoliosis. A magnetic resonance imaging (MRI) of 7/30/10 demonstrated a right Paris Central disc protrusion at L5-S1 with minimal effacement of the thecal sac. The provider noted on 12/31/10 that the patient had not reached maximum medical improvement. The patient was described as having feelings of depression, anxiety and emotional disruption as a result of injury. She was diagnosed with lumbar strain and right lower extremity radiculopathy on 3/14/11. The patient has completed 10 sessions of a work conditioning program with complaints of high levels of pain. A request has been made for authorization of a Chronic Pain Management Program x 80 hours (97799). The Carrier has denied this request citing a lack of medical necessity.

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

Applying the Official Disability Guidelines (ODG), the requested Chronic Pain Management Program is not medically necessary for management of this patient's medical condition. Per the ODG on chronic pain, the diagnosis should not be primarily a personality disorder or psychological condition without a physical component. This patient has shown both severe depression and severe anxiety on psychological testing. The patient's physical condition is a lumbosacral sprain, which typically heals within approximately six weeks. While reference is made to a compression fracture, the documentation indicates the fracture is small (10%) and is stable which indicates that it is an old fracture and is not related to the current injury. For these reasons, the patient does not meet the ODG criteria demonstrating the medical necessity of the requested Chronic Pain Management Program.

Therefore, I have determined the requested Chronic Pain Management Program x 80 hours (97799) is not medically necessary for treatment of the patient's medical condition.

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

[X]DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGMENT, 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)