

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: December 30, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5xWk x 2Wks 80Hrs 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 chronic pain management program 5xWk x 2Wks 80Hrs 97799 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 12/14/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/15/11.
3. Notice of Assignment of Independent Review Organization dated 12/15/11.
4. Physical Performance Evaluations dated 9/28/11, 10/06/10, 11/02/10, 2/16/11 and 3/15/11.
5. Pain Questionnaire dated 9/28/11.
6. Individual Psychotherapy Treatment Reassessment Summary dated 9/01/11.
7. Psychological Testing Results dated 7/01/11.
8. Initial Behavioral Medicine Consultation dated 5/10/11.
9. Right shoulder imaging dated 4/02/10.
10. Electrodiagnostic report dated 10/19/10.
11. MRI of the right shoulder dated 10/26/10.
12. Chronic Pain Management Program Preauthorization Request dated 10/11/11 and 11/04/11.
13. Referral from DO for a chronic pain management program dated 5/04/11.
14. Chronic Pain Management Interdisciplinary Plan and Goals of Treatment dated 5/10/11.
15. Medical records from DO dated 9/06/11 through 11/15/11.
16. Environmental Intervention Form from PsyD dated 10/13/11.
17. Texas Workers' Compensation Status Reports dated 4/02/10 through 6/20/11.
18. Medical records from Medical Clinic dated 4/02/10 through 7/21/11.
19. Functional Abilities Evaluations dated 10/06/10 and 4/25/11.
20. Report of Evaluations dated 12/28/10, 4/11/11 and 7/19/11 and amendment.
21. Medical records from MD dated 1/26/11.
22. Document entitled Impairment Rating by DO.
23. Notes from LPC dated 8/10/11 through 9/01/11.
24. Laboratory results dated 10/04/11 through 11/15/11.
25. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury to the right shoulder on xx/xx/xx. Per the patient, he first sought medical treatment for this injury on xx/xx/xx. The medical records noted that x-ray of the right shoulder revealed moderate to severe degenerative hypertrophy at the right acromioclavicular joint, mild degenerative hypertrophy and joint space narrowing at the right glenohumeral joint. No fracture or dislocation was seen. Per the submitted documentation, MRI of the right shoulder on 10/26/10 showed an acute full thickness tear of the distal supraspinatus tendon at the anterior humeral attachment. The patient presented on 9/01/11, and the medical records noted chronic pain disorder associated with both psychological factors and a medical condition. The medical records noted major depressive disorder, single episode, severe, without

psychotic features. Coverage for a chronic pain management program 5xWk x 2Wks 80Hrs 97799 has been requested.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that in light of MRI documentation of a full thickness tear of the distal supraspinatus tendon, there is no clear documentation of an absence of other options likely to result in significant clinical improvement. On appeal, the URA indicated that the rehabilitation exercises of the pain management program might be detrimental in light of the MRI findings.

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

As per ODG criteria for the general use of multidisciplinary pain management programs, outpatient pain rehabilitation may be considered medically necessary when the patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months. Additionally, per the ODG criteria, there must be evidence of three or more of the following: excessive dependence on health care providers, spouse, or family; secondary physical deconditioning; withdrawal from social activities or normal contact with others; failure to restore pre-injury function such that physical capacity is insufficient to pursue work family or recreational needs; development of psychosocial sequelae that limits function or recovery; the diagnosis is not primarily a personality disorder or psychological condition without an physical component; and there is evidence of continued use of prescription pain medications without evidence of improvement in pain or function. In this patient's case, the medical records noted that the chronic pain disorder is associated with a physical condition. He also has physical deconditioning, and pre-injury function has not been restored. This patient meets ODG criteria for participation in the pain management program. The exercises in a chronic pain management program are designed to help the patient realize the maximum extent of his function, without making the damage that is present worse. The chronic pain management program will not repair the patient's shoulder, but will help him to reach his highest level of function with his current injuries. All told, the requested chronic pain management program 5xWk x 2Wks 80Hrs 97799 is medically necessary in this patient's case.

Therefore, I have determined the requested chronic pain management program 5xWk x 2Wks 80Hrs 97799 is 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**
- 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)**