

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: January 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 additional chronic pain management program visits/80 hours.

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 service, 10 additional chronic pain management program visits/80 hours, is not medically necessary for treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury to his left knee on xx/xx/xx. The patient underwent a total left knee replacement and has reportedly undergone injections, physical therapy, work hardening program and individual psychotherapy with limited success. The patient

also underwent psychological testing on 9/21/11. The patient has participated in 20 days/160 hours of a chronic pain management program. The patient's provider has requested authorization for 10 additional chronic pain management program visits/80 hours. The Carrier indicates the requested services are not medically necessary. Specifically, the Carrier states that the patient's improvement after 160 hours of chronic pain program treatment has been minimal, the patient is not requiring any injury-related pain medications and his psychological parameters are not objectively improved after 160 hours of the chronic pain program. The Carrier additionally states that the request for additional treatment does not provide a clear individualized care plan explaining why improvements cannot be achieved without an extension.

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 patient is status post total knee replacement and has participated in 160 hours of chronic pain management program visits. According to the Official Disability Guidelines (ODG), "Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part time work, transportation, childcare or comorbidities). Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed)."

Upon review of the submitted documentation, this patient does not meet ODG criteria for additional chronic pain management program visits. There is no indication that the patient experienced surgical complications or that the post-operative recovery period was abnormal. Further, the patient is not requiring injury-related pain medications. While the provider indicates the patient may not be able to meet the demands of his work as a, this rationale is not sufficient to support continuation of chronic pain management program, as the Medical Disability Advisor indicates that individuals who undergo total knee replacement may not be able to return to medium, heavy or very heavy work. All told, there is a lack of a clear rationale for the specified extension and an absence of reasonable goals to be achieved. Therefore, the patient does not meet ODG criteria for the requested services.

For the reasons set forth above, I have determined the requested 10 additional chronic pain management program visits/80 hours are 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 KNOWLEDGBASE

- 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)**