

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 Review Decision

DATE OF REVIEW: July 8, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 days/80 hours of Chronic Pain Management Program (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)

I have determined that the requested Chronic Pain Management Program x 80 hours/10 days (CPT 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 6/14/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/17/13.
3. Notice of Assignment of Independent Review Organization dated 6/18/13.
4. Denial documentation dated 5/23/13 and 6/6/13.
5. Request for 80 Additional Hours of Chronic Pain Management Program dated 5/21/13.
6. Physical Performance Evaluation dated 2/5/13 and 5/9/13.
7. Interdisciplinary Pain Treatment Components.
8. Chronic Pain Management Program Design.
9. Chronic Pain Management Program (CPMP) Treatment Design.

10. Preauthorization request dated 6/3/13.

11. Reassessment for Chronic Pain Management Program Continuation dated 4/30/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury to her lower back on xx/xx/xx. The medical records indicate the patient's injury is a lumbar strain/sprain. The submitted documentation does not indicate clinical radiculopathy. The patient's treatment has been conservative and she has had a trial of lumbar epidural steroid injection performed, which was not helpful. Six sessions of psychotherapy have been tried as has 10 days of a chronic pain management program.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that ODG recommends no more than an initial trial of two weeks without evidence of compliance and significant demonstration of program efficacy. Also, the URA states the submitted documentation shows equivocal changes in psychometric and physical capabilities and there was no documentation of compliance and medication titration. On 6/6/13, the URA reported that the request was again non-certified. According to the URA, treatment is not suggested for longer than two weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.

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

In this patient's case, the Official Disability Guidelines (ODG) do not support the requested chronic pain management program. Review of the submitted documentation does not reveal evidence of radiculopathy. The patient's symptoms are consistent with lumbar strain/sprain. Lumbar strains/sprains are self-limited injuries. A pain management program is not recommended by the ODG for treatment of the patient's injury. As such, the chronic pain management program is not considered medically necessary.

In conclusion, I have determined the requested Chronic Pain Management Program x 80 hours/10 days (CPT 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
- 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)