

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: February 28, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 days chronic pain management program.

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 and Pain Management.

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 10 days chronic pain management program is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male with a reported date of injury of xx/xx/xx. He was seen on xxxxxreporting that his pain had been constant at that time and he was unable to fully carry out his activities. He reported radiating pain down to his left foot to his toes and right lower extremity radiation of pain down to his knee level. The pain was rated at 8/10 at that time. He was taking morphine, Cymbalta, Norco, Xanax, Flexeril and gabapentin. On examination, he appeared to be agitated

and he had decreased range of motion in the lumbar spine. He had decreased deep tendon reflexes at the right lower extremity, and he had decreased muscle strength in the left lower extremity that was rated at 3/5. He was also experiencing increased bowel/bladder symptoms at that time. Straight leg raise was positive. He was given a lumbar transforaminal epidural steroid injection on 5/10/13. On 6/24/13, he was seen back in clinic and still reported pain at 6/10. He reported the last procedure relieved his pain 80% to 100% for four weeks. At that time, the bilateral straight leg raise was positive at 30 degrees reproducing concordant ipsilateral extremity and neuropathic pain. Strength was rated at 3+/5 in the left quadriceps and 4/5 in the left gastroc soleus. He had decreased sensation to light touch in the right L4 nerve root distribution and decreased sensation to light touch in the left L5 and left S1 nerve root distribution. Patellar reflexes were 0/4 and Achilles reflexes were 1/4 at that time. On 11/29/13, initial diagnostic screening for mental health testing was performed. On his pain drawing, his pain was 6/10. On sleep questionnaire, he scored 43. On Beck Anxiety Inventory test, he scored 34. On his Beck Depression Inventory, he scored 24. It is reported this was a decrease of 6 points during the treatment phase on his Beck Anxiety Inventory score and a decrease of 6 points during the treatment phase on his Beck Depression Inventory. The patient has requested coverage for 10 days chronic pain management program.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that for patients that have been continuously disabled for greater than 24 months, there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. Some of the negative predictors of program efficacy and completion include higher pretreatment levels of depression, pain and disability, which the patient has. On appeal, the URA noted that there is insufficient information to support a change in determination.

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

The submitted records indicate that this patient has a date of injury of xx/xx/xx. The records provided for this review indicate that the mental health testing only revealed a 6 point difference between his Beck Depression Inventory and his Beck Anxiety Inventory when he was in chronic pain program. His pain was still rated at 6/10 which did not document significant improvement. It is reported that he has been recommended for lumbar surgery and has deferred that treatment at this time. Official Disability Guidelines state if a program is planned for a patient who has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. Therefore, based on the records provided, the previous determination is upheld. The requested services are not medically necessary for treatment of the patient's medical condition.

Therefore, I have determined the requested 10 days chronic pain management program 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)**