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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 04/07/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Program 10 sessions/80 hours CPT 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 & Rehabilitation with a sub-specialty in Pain 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 Program 10 sessions/80 hours CPT 97799 is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on XX/XX/XX. His diagnoses were noted to include sacroiliitis and lumbar sprain. An MRI of the lumbar spine was performed on XX/XX/XX that showed straightening of the lumbar spine with absence of normal lordosis, mild right foraminal stenosis at the L3-4 level, mild degenerative disc disease at the L4-5 level with a disc bulge and moderate bilateral foraminal stenosis, mild degenerative disc disease at the L5-S1 level with a disc bulge and mild left foraminal stenosis and moderate right foraminal stenosis. A Functional Capacity Evaluation was performed on XX/XX/XX which showed the patient was capable of heavy duty activities at work and he does not routinely use narcotic medication for

pain symptoms. On XX/XX/XX, it was documented the patient was able to stand, sit, and walk for less than 30 minutes. He had complaints of pain to the low back that he rated 4/10 to 6/10. Physical examination showed no significant abnormal findings.

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

According to the Official Disability Guidelines, the criteria for a chronic pain management program is documentation noting excessive dependence on others for functioning, withdrawal from social activities, evidence of continued use of prescription pain medication, failure of previous methods of conservative care, and treatment is not to exceed 160 hours. The clinical documentation submitted for review indicated the patient had complaints of pain and this request did not exceed the guidelines' recommended duration of treatment; however, there was lack of information noting that this patient was excessively dependent on others for functioning and activities of daily living. There was also a lack of information noting the failure of conservative care and the Functional Capacity Evaluation showed he was capable of performing heavy duty activities. As such, the request services are not medically necessary.

Therefore, I have determined the requested Chronic Pain Program 10 sessions/80 hours 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 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)