

SENT VIA EMAIL OR FAX ON  
Feb/04/2011

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/04/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management X 40 hours

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Anesthesiologist/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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**OD Guidelines**

The submitted medical records include the cover sheet and working documents, utilization review determination dated 01/06/11, office visit note dated 11/23/10, utilization review determination dated 11/22/10, 11/15/10, weekly progress report dated 11/01/10-11/05/10, 10/25/10-10/29/10, utilization review determination dated 11/01/10, weekly progress report dated 10/18/10-10/22/10, 10/11/10-10/15/10, letter dated 12/13/10, weekly progress report dated 11/29/10-12/03/10, preauthorization request dated 10/11/10, behavioral health assessment dated 09/22/10, follow up note dated 09/22/10, functional capacity evaluation dated 09/22/10, treatment plan, preauthorization request dated 12/29/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell from a ladder fracturing bones in his bilateral ankles. Treatment to date includes bilateral ankle ORIF on 06/10/09 and hardware removal bilateral ankles on 05/07/10 with bone grafts, medication management, individual psychotherapy and work hardening program. Functional capacity evaluation dated 09/22/10 indicates that required PDL is medium and current PDL is light/medium. Behavioral health assessment dated 09/22/10 indicates that the patient has undergone 3 surgeries to each ankle. BDI is 34 and BAI is 47. The patient subsequently completed 20 sessions of chronic pain management program. Request for additional 80 hours of CPMP was non-certified on 11/15/10 noting that the request exceeds ODG

guidelines. The patient has obtained some progress, but continues to use opioid medication and continues to need an assistive device for walking. A partial approval of 5 sessions of chronic pain management program was negotiated on 11/22/10. The patient subsequently completed an additional 5 days of chronic pain management. Note dated 12/13/10 indicates that the patient's lifting capability has improved and cardiovascular tolerance has increased to 60 minutes. Depressive symptomatology is now in the mild range. Tylenol #4 has been reduced from 8 each day to 2 a day. The request for 40 additional hours of chronic pain management program was non-certified on 01/06/11 noting that the patient has completed 25 sessions of CPMP and treatment update dated 12/29/10 indicates that the patient has obtained progress toward stated treatment goals; however, he continues to use opioid medication and no significant gains have been documented since the 5 session extension of the program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the clinical information provided, chronic pain management program x 40 hours is not recommended as medically necessary, and the previous denials are upheld. The patient has completed 25 sessions of chronic pain management program to date. Current evidence based guidelines do not generally support more than 20 sessions of chronic pain management program. The initial functional capacity evaluation dated 09/22/10 indicates that the patient's required PDL was medium and the patient's PDL at the time was light/medium, half of a level lower than the required physical demand level. The patient completed 25 sessions of chronic pain management program and was unable to achieve the physical demand level required to return to work, and significant gains are not documented to support continuing to exceed evidence-based guidelines. There are no exceptional factors of delayed recovery documented. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary and the previous denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)