

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: March 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of chronic pain management program

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

MD, Certified by the American Board of Psychiatry and Neurology

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

Adverse Determination Letters, 1/18/11, 2/1/11

Official Disability Guidelines

Pain Center 1/5/11 to 1/26/11

Medical Center 8/20/10 to 12/21/10

Hand Center 8/2/10

Hand and Plastic Surgery 4/13/10

Physical Therapy 2/16/10 to 6/2/10

Renaissance 1/18/10

Workers Comp Doctors Notes 9/3/10 to 10/25/10

Imaging 3/2/10

Clinic 7/14/09

Medical Center 2/25/09 to 4/14/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a man who was injured at work on xx/xx/xx. He apparently tripped and then fell about 5 feet losing consciousness and sustaining a post-injury headache. He also sustained injuries to his back, left knee, right shoulder, right hand and left knee. He has undergone left knee arthrocentesis, pain injections, MRI of head and knee, arthroscopic surgery, physical therapy and EMG/NCV studies. His functional evaluation showed that he is not able to perform heavy work as required by his job. He has also had a mental health evaluation and diagnosed with Pain disorder. A request was made for 10 sessions of CPMP. This was denied by the reviewer, who stated an adequate multidisciplinary evaluation had not been conducted and other treatment options had not been ruled out. The reviewer also did not approve of the instruments used to evaluate the patient psychologically. The treatment team responded with an appeal letter that described in great detail the patient's medical history and explained that all treatment options have now been exhausted. They also cited specific

references to justify the instruments they used in the evaluation.

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

This patient's treatment team has shown in great detail that all ODG requirements are fully met by their request. In the original request, they actually went through each criteria of ODG and showed how the patient met it. In the appeal letter, they went issue by issue and fully explained how ODG criteria were used and fulfilled. There is no question from the documentation that the request fulfills ODG. The reviewer finds there is medical necessity for this patient for 10 sessions of chronic pain management program.

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)