

SENT VIA EMAIL OR FAX ON  
May/10/2011

## P-IRO Inc.

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

**DATE OF REVIEW:**

May/09/2011

**IRO CASE #:**

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

Chronic Pain Management X 10 sessions

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

Board Certified PMR 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 03/02/11, 03/18/11
3. Employer's first report of injury or illness
4. Office visit note dated 09/22/08, 09/26/08, 10/03/08, 10/15/08, 10/29/08, 11/24/08, 12/22/08, 12/15/08, 10/20/08, 11/17/08, 12/08/08, 01/26/09, 02/02/09, 02/04/09, 02/24/09, 03/11/09, 04/01/09, 05/18/09, 06/15/09, 06/23/09, 09/10/09, 09/14/09, 10/01/09, 10/10/09, 10/26/09, 11/12/09, 12/16/09, 12/18/09, 12/19/09, 01/28/10, 02/08/10, 03/29/10, 04/29/10, 05/28/10
5. Letter dated 06/09/10, 04/17/11
6. Daily soap notes dated 07/12/10, 07/19/10, 07/27/10, 08/12/10, 08/09/10, 08/11/10, 08/16/10, 08/19/10, 08/23/10, 09/02/10, 09/09/10, 09/14/10, 09/20/10, 09/28/10, 10/04/10, 10/06/10, 10/12/10, 10/19/10, 10/26/10, 11/02/10, 11/17/10, 11/09/10, 11/23/10
7. Individual psychotherapy note dated 11/09/10-11/16/10, 11/30/10, 12/02/10
8. Request for chronic pain management program dated 02/24/11
9. Behavioral health evaluation dated 02/17/11
10. Designated doctor evaluation dated 08/31/10
11. Functional capacity evaluation dated 05/04/10, 02/15/11
12. Reconsideration dated 03/10/11
13. Letter of medical necessity dated 02/22/11
14. Impairment letter dated 04/26/10
15. Urine drug screen dated 12/16/09
16. Anesthesia record dated 02/24/09
17. Impairment rating dated 03/09/09
18. Work status reports

19. MRI left wrist dated 09/30/08
20. MRI of the cervical spine dated 12/30/08

#### **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a XX year old female whose date of injury is XX/XX/XXXX. On this date the patient tripped over a box and fell. MRI of the left wrist dated 09/30/08 revealed evidence of bony contusion with incomplete fracture and cortical buckling of the distal metaphysis of the distal radius. MRI of the cervical spine dated 12/30/08 revealed degenerative changes and desiccation throughout the cervical spine more so at C5-6 and C6-7 with disc space narrowing and spondylitic changes as well as mild bulging of the disc and mild bilateral neural foraminal narrowing. Treatment to date includes physical therapy, right C5-6 transforaminal epidural steroid injection on 02/24/09, immobilization, massage therapy, medication management. Urine drug screen dated 12/16/09 was positive for Tramadol which was not matched to any of the patient's prescriptions. Impairment letter dated 04/26/10 indicates that the patient's total impairment was 5%. Designated doctor evaluation dated 08/31/10 reports diagnoses are contusion sprain left wrist with no displaced fractures of distal radius and navicular; and strain/sprain cervical aggravating degenerative disc disease and degenerative joint disease with persistent neck and left shoulder pain and sensory loss left upper extremity. The patient was determined to have reached MMI as of this date with 10% whole person impairment. The patient subsequently underwent a course of individual psychotherapy. Functional capacity evaluation dated 02/15/11 indicates that required PDL is heavy and current PDL is light. Psychological evaluation dated 02/17/11 indicates that current medications include Lortab, Tramadol, Zoloft and Ambien. BDI is 23 and BAI is 25. Diagnoses are adjustment disorder and chronic pain syndrome.

Initial request for chronic pain management x 10 sessions was non-certified on 03/02/11 noting that it is unclear why the patient was taken off of work and why she has not attempted to return to work since at a light PDL or modified duty. There is no validated functional capacity evaluation available for review, and it is not clear if her doctor has attempted to reduce her medication use. The denial was upheld on appeal dated 03/18/11 noting there is no valid, physiologically matched functional capacity evaluation demonstrating baseline limitations to preclude gainful employment. There is no explanation as to how a claimant who has only had 2 prescriptions filled since 04/2010 would be referred for a comprehensive, tertiary chronic pain management program. The claimant has not worked since July 2010 and there is no evidence of demonstrated motivation to return to gainful employment.

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

Based on the clinical information provided, the request for chronic pain management x 10 sessions is not recommended as medically necessary, and the two previous denials are upheld. There is no current, valid functional capacity evaluation submitted for review to establish baseline levels of functioning as well as the patient's current physical demand level. There is no documentation that the patient is motivated to return to work at this time. The patient has reportedly had only two prescriptions filled since April 2010. The patient has been placed at MMI by a designated doctor as of 08/31/10 with 10% whole person impairment. The patient's date of injury is greater than 24 months old, and the Official Disability Guidelines do not recommend chronic pain management programs for patients whose date of injury is greater than 24 months old. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**