

SENT VIA EMAIL OR FAX ON  
Jan/09/2012

## **P-IRO Inc.**

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

**DATE OF REVIEW:**

Jan/09/2012

**IRO CASE #:**

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

Chronic Pain Management Program 5 X week X 2 weeks for the bilateral shoulders

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

PM&R and 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 11/14/11, 10/22/11

Peer review report dated 11/10/11, 10/20/11

Letter of reconsideration dated 10/25/11

Request for 10 sessions of chronic pain management dated 09/02/11

Team treatment plan dated 09/02/11

Vocational assessment note dated 09/02/11

Medical clearance dated 09/28/11

MMI/IR evaluation dated 09/23/11

Psychological diagnostic interview dated 09/02/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was holding the door open with her right hand and leg and was given a 45 lb box to carry. She carried

several heavy boxes to the back and immediately felt pain in her left shoulder. At the time of her second injury she picked up a gallon of bleach and felt pain in her right shoulder. She underwent left shoulder arthroscopic rotator cuff repair and subacromial decompression on 11/22/10 that has helped restore partial functionality to her left shoulder. Psychological evaluation dated 09/02/11 indicates that treatment to date includes diagnostic testing, physical therapy x 18, surgical intervention and medication management with marginal results. BDI is 27 and BAI is 26. Current medication is Aleve OTC prn. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. MMI/IR evaluation dated 09/23/11 indicates that diagnosis is left rotator cuff sprain-status post arthroscopic left rotator cuff repair and subacromial decompression on 11/22/10; adhesive capsulitis-left shoulder and thoracic sprain. The patient was determined to have reached MMI as of 09/23/11 with 6% whole person impairment.

Initial request for chronic pain management program was non-certified on 10/22/11 noting that there is no documentation of realistic and quantifiable goals achievable within a specified time period. The denial was upheld on appeal dated 11/14/11 noting that the patient has completed four sessions of individual psychotherapy with some improvement. The claimant is not currently taking any prescription medications. There is insufficient clinical documentation of a functional capacity evaluation submitted for review.

**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 program 5 x week x 2 weeks for the bilateral shoulders is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient has reportedly undergone a course of individual psychotherapy, per previous review; however, no individual psychotherapy notes were provided. The patient is not currently taking any opioid medications and only takes over the counter ibuprofen. There are no treatment records submitted for review. There is no current functional capacity evaluation provided to establish baseline levels of functioning as well as current versus required physical demand level. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary.

**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)