

SENT VIA EMAIL OR FAX ON
Dec/29/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program X 10 sessions

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

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 10/31/11, 11/22/11
Employer's first report of injury or illness
Associate statement dated 01/15/10
Notice of denial of compensability/liability and refusal to pay benefits dated 03/10/10, 04/07/10
Bona fide job offer dated 10/20/10
Handwritten progress notes dated 01/15/10, 01/22/10, 01/25/10, 01/27/10, 01/29/10, 02/08/10, 02/05/10, 02/10/10, 02/12/10, 02/15/0, 02/17/10, 02/19/10, 02/22/10, 02/24/10, 03/01/10, 03/03/10, 03/08/10, 03/11/10, 03/16/10, 03/24/10, 03/30/10, 04/08/10, 04/14/10, 04/21/10, 04/28/10, 04/29/10, 05/05/10, 05/12/10, 05/14/10, 05/15/10, 05/26/10, 06/02/10, 06/04/10, 06/09/10, 06/11/10, 06/15/10, 06/23/10, 06/25/10, 07/15/10, 07/21/10, 08/01/10, 08/04/10, 08/11/10, 08/12/10, 08/25/10, 09/08/10, 09/16/10, 09/30/10, 10/19/10, 11/10/10, 12/08/10, 01/05/11
Designated doctor evaluation dated 01/06/11

MMI/IR evaluation dated 12/01/2010

Functional capacity evaluation dated 09/30/10, 09/09/11

Office visit note dated 04/21/10, 05/05/10, 05/19/10, 07/09/10, 12/06/10, 01/12/11, 01/19/11, 02/01/10, 02/02/11, 02/11/11, 03/01/11, 03/08/11, 03/11/11, 03/28/11, 03/31/11, 04/05/11, 04/11/11, 04/25/11, 05/04/11, 05/17/11, 05/24/11, 05/25/11, 05/31/11, 06/15/11, 06/22/11, 06/28/11, 07/25/11, 08/02/11, 08/09/11, 08/16/11, 08/24/11, 09/06/11, 09/27/11, 09/21/11, 10/05/11, 10/11/11, 10/17/11, 10/19/11, 11/21/11, 11/29/11

Notice of independent review decision dated 04/13/11, 07/29/11

Behavioral health evaluation dated 04/01/11, 09/15/11

New patient surgical consultation dated 03/08/11

Letter dated 03/11/11

MMT/ROM testing dated 01/29/10, 02/19/10, 03/08/10, 04/28/10, 06/11/10, 07/23/10, 08/06/10

MRI left hip dated 03/09/10

MRI left knee dated 03/09/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell on a wet floor. Treatment to date includes physical therapy, left knee injections, left hip injections, diagnostic testing and medication management. Maximum medical improvement determination and impairment rating evaluation dated 12/01/10 indicates that the patient reached MMI as of this date with 4% whole person impairment. Designated doctor evaluation dated 01/06/11 indicates that the patient has 3 out of 8 positive Waddell's tests which is significant for symptom magnification. Diagnoses are nonspecific lower back pain, sprained left knee and sprained left hip. The patient was determined to have reached maximum medical improvement as of 12/01/10 with 0% whole person impairment. Behavioral health evaluation dated 04/01/11 indicates that BDI is 26. Diagnosis is depression and pain disorder associated with both psychological factors and a general medical condition. Functional capacity evaluation dated 09/09/11 indicates that current PDL is sedentary and required PDL is light. Behavioral evaluation dated 09/15/11 indicates that BAI is 31 and BDI is 22. Medications include Hydrocodone, Xanax, Soma, Gabapentin, Celebrex and Fiorinal tabs.

Initial request for chronic pain management program was non-certified on 10/31/11 noting that the patient's job was a cake decorator, and it does not appear that she has been in active treatment since 2010. The patient's medications have been reduced overall, but it is not clear why they have not continued to reduce the medications. The denial was upheld on appeal dated 11/22/11 noting that there is no evidence to support the prescribing practice of the providers involved in the treatment of this claimant. Records reflect poly-pharmacy with no attention to functionality. There is nothing to support perpetuation of claimant status due to practice pattern of the treating physician. Iatrogenesis is not a basis to support a referral to any tertiary chronic pain program. There is no demonstrated motivation for recovery; there are no serial drug screens on the file.

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 x 10 sessions is not recommended as medically necessary, and the two previous denials are upheld. The patient has been placed at maximum medical improvement as of 12/01/10 with 0% whole person impairment by a designated doctor. This report indicates that the patient had 3 out of 8 positive Waddell's tests which is significant for symptom magnification. The patient has been diagnosed with depression; however, there is no indication that the patient has undergone a course of individual psychotherapy. The patient's required physical demand level is light, and it is unclear why this PDL cannot be reached with a structured, independent home exercise program as recommended by the guidelines. 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)