

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/18/2012

**IRO CASE #:**

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

Chronic pain management program/functional restoration program x 10

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

M.D., Board Certified Anesthesiology/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**

Official Disability Guidelines & Treatment Guidelines

Psychological evaluation dated 03/01/11

Peer review report dated 04/27/11

History and physical chronic pain management program dated 04/11/12

Functional capacity evaluation dated 04/18/12

Chronic pain management interdisciplinary plan and goals of treatment 04/18/12

Psychological assessment report dated 05/02/12

Chronic pain management preauthorization request dated 05/08/12

Utilization review determination dated 05/11/12

Chronic pain management reconsideration request dated 05/21/12

Utilization review determination dated 05/29/12

**PATIENT CLINICAL HISTORY SUMMARY**

This male patient was injured on xx/xx/xx when he was pinned between two pallets. He has had diagnostic testing, physical therapy, individual psychotherapy x 6 and medication management. Peer review dated 04/27/11 indicates that it is not medically probable that the patient sustained any acute structural damage to the lumbar or cervical spine. Diagnosis is lumbar strain. The patient was released to work without restrictions on 10/13/10. Functional capacity evaluation dated 04/18/12 indicates that required PDL is medium and current PDL is sedentary. Assessment dated 04/18/12 indicates that BDI is 47 and BAI is 46. Current medications include Vicodin, Paxil, Lortab, Orphenadrine citrate, Naprosyn and Nabumetone. Diagnoses are pain disorder associated with both psychological factors and a general medical condition, chronic; and major depressive disorder, single episode, severe without psychotic features. Psychological assessment dated 05/02/12 indicates that MMPI protocol was valid. A request for chronic pain management program/functional restoration program x 10 was non-certified on 05/11/12 noting that the mental health evaluation is inadequate as an

evaluation for admission to a comprehensive pain management program. There is no reasonable MMPI-2-RF profile interpretation, and result is not integrated in the evaluation. The peer review notes only that the claimant sustained a lumbar strain and possible cervical strain on the date of injury, which would have resolved within 8 weeks post-injury. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem. The denial was upheld on appeal dated 05/29/12 noting that there is no evidence that the treatment team has exhausted all appropriate treatments for this patient. It remains unclear why such an extensive interdisciplinary program would be needed for an individual where reportedly there is minimal identifiable physical pathology, he is reporting minimal to mild psychological symptoms, the patient was placed at MMI, and has already been cleared to return to work without restrictions.

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

This patient was released to work without restrictions on 10/13/10. A peer review report that is dated 04/27/11 indicates that it is not medically probable that this patient sustained any acute structural damage to the lumbar or cervical spine. Diagnosis is lumbar strain, which should have resolved at this time. 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 ODG criteria for CPMP require that there be an absence of other options likely to result in significant clinical improvement. The reviewer finds no medical necessity exists for Chronic pain management program/functional restoration program x 10.

**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)