

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Mar/05/2014

### IRO CASE #:

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

10 sessions of chronic pain management program, 5 X wk X 2 wks 80 units

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

Board Certified Anesthesiologist

### 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization reviews dated 02/07/14, 02/19/14

Request for reconsideration

Behavioral evaluation dated 01/22/14

Functional capacity evaluation dated 01/29/14

Handwritten office visit note dated 11/27/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient slipped and both feet went in the air, causing him to land on his back. He also attributes the injury to bending over repeatedly. Behavioral evaluation dated 01/22/14 indicates that treatment to date includes x-rays, MRI, physical therapy, pain injections, TENS unit, spinal cord stimulator and surgery. Current medications are listed as hydrocodone, tizanidine and Zolpidem. The patient denies being currently or ever being treated for psychiatric needs. The patient reports that he is unsure about his desire to return to work. BDI is 10 and BAI is 5. FABQ-W is 32 and FABQ-PA is 24. Functional capacity evaluation dated 01/29/14 indicates that required PDL is heavy and current PDL is less than sedentary.

Initial request for 10 sessions of chronic pain management program was non-certified on 02/07/14 noting that the claimant has been almost 10 years post injury. His psych scores do not warrant the amount of psychological behavioral treatment that he is going to get. The denial was upheld on appeal dated 02/19/14 noting that the Official Disability Guidelines state

that participation in multidisciplinary pain management is indicated when there is development of psychosocial sequelae that limits function or recovery. The provided psychological testing indicated that the claimant did not suffer from significant depression or anxiety. There should be documentation of an adequate and thorough multidisciplinary evaluation, and no physical examination findings with recent diagnostic studies were provided for review which ruled out other options of treatment to provide significant clinical improvement.

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

The Official Disability Guidelines do not generally recommend chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. The behavioral evaluation dated 01/22/14 states that "he reports his financial situation is not a major stressor at this time, and is unsure about his desire to return to work". The patient does not present with significant psychosocial indicators to support a multidisciplinary program. As such, it is the opinion of the reviewer that the request for 10 sessions of chronic pain management program, 5 x wk x 2 wks 80 units is not recommended 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)