

# C-IRO Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Apr/01/2016

**IRO CASE #:**

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

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O. Board Certified Physical Medicine and Rehabilitation; Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for Chronic Pain Management Program x 10 sessions is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is XX/XX/XX. On this date the patient fell and injured her back, left ankle and knee. The patient underwent left knee arthroscopy with chondroplasty, partial medial and lateral meniscectomy on XX/XX/XX. The patient underwent left ankle arthroscopy on XX/XX/XX. The patient completed a functional restoration program in XXXX. RME dated XX/XX/XX indicates that assessment is lumbar strain/sprain, left shoulder strain/sprain, left hip contusion, torn left medial meniscus, left ankle sprain and/or fracture and prolonged disability and marked pain behavior. The claimant should stay active and continue a home exercise program. She needs no other specific care as it is doubtful that additional care otherwise will provide any long-lasting improvement. She remains significantly depressed as a pre-existing condition. Note dated XX/XX/XX indicates that the patient has had multiple sessions of physical therapy with minimal or no help. The patient is not working. On physical examination cervical range of motion is normal. There is bilateral facet tenderness in the cervical area. Heel and toe walking are poor. Deep tendon reflexes are diminished in the lower extremities. Straight leg raising is negative. Waddell's signs are positive for axial compression rotation straight leg raising. Pain amplification is noted. The patient was recommended for psych, functional capacity evaluation and pain program. It is reported that she has a lot of psychological issues. Behavioral evaluation dated XX/XX/XX indicates that treatment to date includes x-rays, MRI, physical therapy, surgery, work conditioning and medication management. BDI is 35 and BAI is 32. Functional capacity evaluation dated XX/XX/XX indicates that current PDL is sedentary and required PDL is light. Office visit note dated XX/XX/XX indicates that the patient complains of low back pain and neck pain rated as 7-9/10. There are no significant changes on physical examination. Diagnoses are chronic pain syndrome, sprain of neck and sprain of lumbar spine. Current medication is Mobic.

Initial request for pain management program x 10 sessions was non-certified on XX/XX/XX noting that the requesting provider was not aware that he patient had participated in a functional restoration program in XX/XX/XX. The functional capacity evaluation had not been

completed, and a repeat program is not supported by the Official Disability Guidelines. The denial was upheld on appeal dated XX/XX/XX noting that the patient has an injury that is 5 years old and continues to take medication without objective examination findings of an ongoing injury and without returning to work. There is a history of CPMP participation in XXXX without change in functional outcome. Current functional capacity evaluation is invalid. The patient refused almost all activity due to pain complaints.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in XX/XX as a result of a fall and has undergone extensive treatment including a prior chronic pain management program in XXXX. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. The Official Disability Guidelines generally do not 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. There is no confirmation through validity testing that the patient's reported symptoms are accurate. Note dated XX/XX/XX indicates that Waddell's signs are positive for axial compression rotation straight leg raising. Pain amplification is noted. RME dated XX/XX/XX indicates that assessment is lumbar strain/sprain, left shoulder strain/sprain, left hip contusion, torn left medial meniscus, left ankle sprain and/or fracture and prolonged disability and marked pain behavior. The claimant should stay active and continue a home exercise program. She needs no other specific care as it is doubtful that additional care otherwise will provide any long-lasting improvement. As such, it is the opinion of the reviewer that the request for Chronic Pain Management Program x 10 sessions is not recommended as medically necessary and the prior denials are upheld.

**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)