

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070

Office 214-533-2864 Fax 214-380-5015

e-mail: [independentreviewers@hotmail.com](mailto:independentreviewers@hotmail.com)

**[Date notice sent to all parties]:**

**1/25/2016 and 1/27/2016**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Functional Restoration Program for the Left Shoulder, initial 80 hours, for the diagnosis of sprain and strain of the left shoulder, as an outpatient.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified Orthopedic Surgeon.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X  OVERTURNED

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a male with complaints of nonradiating left shoulder pain (with accepted "sprain/strain").

On XX/XX/XX, the injured employee was evaluated. The diagnostic impression was chronic left shoulder sprain/strain pain with current physical exam findings of muscle guarding and mobility deficits with multitendon tendinosis by imaging with desire to avoid decompression surgery, noncompensable deconditioning syndrome and noncompensable chronic pain syndrome. The plan was an interdisciplinary evaluation.

On XX/XX/XX the injured employee followed-up. The plan was a restoration

program.

An FCE and Mental Health Evaluation was performed on XX/XX/XX.

On XX/XX/XX, XX denied the request for a functional restoration program.

An appeal was made on XX/XX/XX.

On XX/XX/XX, XX wrote a reconsideration letter.

On XX/XX/XX the appeal was denied.

On XX/XX/XX, XX wrote an Override Letter of the double denial.

On XX/XX/XX, XX wrote a letter requesting an overturn for the denial of the restoration program.

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

This gentleman has received appropriate ODG recommended therapy after his injury and surgery, and he has improved. He is still not able to function at the pre-injury level. Due to improvement without recovery, his findings are consistent with the criteria required by the ODG for this program.

Therefore, the request for certification for this procedure is certified due to compliance with accepted indications and for compliance with ODG recommendations.

### **ODG criteria for pain management**

#### **Criteria for the general use of multidisciplinary pain management programs:**

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that req