P-IRO Inc.

An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain/Functional Restoration Program X XX hours

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX was diagnosed with unspecified sprain of XXXX XX, subsequent encounter (XX.XX), unspecified sprain of XXXX foot, subsequent encounter (XX.XX). XXXX also had a XX XX syndrome. XXXX was evaluated by XXXX for pain in the XXXX foot and XXXX XX. The pain was rated at XX/10. XXXX had been evaluated for entrance into the interdisciplinary functional program. On XX examination, XXXX had tenderness in the XX and XX XX interspace and tenderness in the XXXX the thumb base. XXXX had cleared XXXX for the interdisciplinary functional program and opined that XXXX was able to return to work with the restrictions. An undated bone scan was negative. An MRI XXXX hand and XXXX foot dated XXXX showed mild XX changes. MRI XXXX wrist dated XXXX showed mild XX of the first XX joint. X-ray XXXX foot dated XXXX was normal. The treatment to date included medications (XXXX), a XX XX, ultrasound, heat, ice, transcutaneous electrical nerve stimulation (TENS) unit, and XX sessions of physical therapy. A functional capacity evaluation (XX) was completed by XXXX on XXXX. XXXX had XXXX hand and XXXX foot pain. There were improvements in the cardiovascular endurance, range of Motion, static strength, dynamic lifting, functional specific testing, hand grip, and pinch as compared to the prior evaluation. XXXX was unable to complete parts of the test due to an increase in acute pain levels and spasms on the

attempted performance of tests. XXXX was severely limited functionally. XXXX could not safely perform XXXX job demands based on a comparative analysis between their required job demands and ongoing evaluation outcomes. The required job demand level (PDL) was medium XX, and XXXX ongoing PDL level was XX. XXXX recommended a functional restoration program to further strengthen and improve functional capabilities as well as improving pain coping mechanisms.

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

Based on the clinical information provided, the request for Chronic pain / outpatient functional restoration program, XX hours, estimated from XXXX XX – Other Physical Medicine and Rehabilitation Service or Procedure is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review letter dated XXXX and peer review dated XXXX, the request for XX hours of interdisciplinary function restoration program for the XXXX foot and hand was denied by XXXX. Rationale: “The history and documentation do not objectively support the request for an interdisciplinary functional restoration program at this time. The Official Disability Guidelines (ODG) state "ODG, 2018. Pain: FRP: Recommended for selected patients with chronic disabling pain, although research is still ongoing as to how to most appropriately screen for inclusion in these programs.” Per a utilization review decision letter dated XXXX and peer review dated XXXX, the prior denial was upheld by XXXX. Rationale: “XXXX has no specific diagnosis, has not seen hand or foot physician, has not seen pain management and has untreated XX. All of these should take place prior to the chronic pain management program. Therefore, XX hours of an interdisciplinary functional restoration program for the XXXX foot and XXXX thumb are not medically necessary.” Reconsideration dated XXXX indicates that the patient completed XX sessions of individual XX on XXXX. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has been determined to have reached maximum medical improvement by a designated doctor. History and physical dated XXXX indicates that XXXX evaluations have been negative. XXXX did have a bone scan and MRI which were negative.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the request is medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL