# C-IRO Inc.

**An Independent Review Organization**
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## *Review Outcome*

***Description of the service or services in dispute:***

*Chronic pain program XX sessions / XX units, XX times a week, related to the XX XX injury*
*XX-CP - Unlisted XX medicine / rehabilitation service or procedure*

***Description of the qualifications for each physician or other health care provider who reviewed the decision:***

Board Certified Anesthesiologist

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

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

***Patient Clinical History (Summary)***

XX. XX XX is a XX-year-old, XX-XX-dominant XX who was injured on XX. XX XX on a XX causing XX to XX XX onto XX XX XX XX. XX underwent XX XX repair with severe XX XX, which had not improved with XX therapy and home therapy. The ongoing diagnosis was strain of muscle(s) and tendon(s) of the XX XX of unspecified XX, initial encounter (XX.XX).

XX. XX was seen by XX, XX on XX for XX extremity pain. XX was able to stand / sit / walk for more than XX minutes. The pain was rated at 4-6/10. XX felt pain like constant soreness and aching pain. The pain was described as shooting, aching, burning, throbbing, and constant. The aggravating factors included standing, sitting, and walking. On examination, there was pain with XX range of motion. There was decreased abduction of the XX XX. XX was unable to place the XX XX behind XX XX, and unable to abduct the XX XX more than 90 degrees. The plan was to proceed with the chronic pain program / functional restoration program.

XX. XX underwent XX Evaluation by XX, XX, XX / XX. XX on XX. The pain resulting from XX injury had severely impacted the normal functioning physically and interpersonally. XX reported frustration and anger related to pain and pain behavior, in addition to decreased ability to manage pain. Pain had reported high XX resulting in all major XX areas. XX. XX would benefit from a course of pain management. It would improve XX ability to cope with pain, XX, XX, and XX, which appeared to be impacting XX daily functioning. XX would be treated daily in a pain management program with both XX and XX modalities as well as medication monitoring. The program was staffed with multidisciplinary professionals trained in

treating chronic pain. The program consisted of, but was not limited to, daily pain and XX management group, XX groups, XX therapy, XX education, medication management, and XX XX as well as XX activity groups. These intensive services would address the ongoing problems of XX, XX, and returning to a higher level of functioning as possible.

Per an office visit dated XX by XX. XX, XX. XX presented for XX extremity pain. XX was able to stand/ sit / walk for more than XX minutes. The pain was rated at 3-4/10. XX felt pain like constant soreness and aching pain. The symptoms were relieved with medications. The XX examination remained unchanged from the prior visit.

XX. XX underwent a Functional Capacity Evaluation on XX. The purpose of the evaluation was to determine the overall XX and functional abilities as it related to the XX demands outlined by the United States Department of Labor in the Dictionary of Occupational Titles. The job specific evaluation was performed in a 100% XX approach, and XX. XX demonstrated the ability to perform XX.6% of the XX demands of XX job as a XX XX. XX. XX demonstrated the ability to perform within the sedentary XX demand category. At the time, XX was able to work full time in a Sedentary XX Demand category, which was below XX job demands category. However, the XX XX occupational base was significantly eroded because XX was unable to power lift XX XX or slightly less, and XX carry XX XX or slightly less. It was to be noted that XX. XX's job as a XX XX was classified within the Medium XX Demand category.

The treatment to date included medications (XX), XX therapy (minimal or no help), and XX surgeries for the XX XX.

Per a utilization review decision letter dated XX, the request for chronic pain program XX sessions / XX units, XX per week, related to the XX XX injury was denied by XX. Rationale: "According to the Official Disability Guidelines, the patient did not meet the criteria for proceeding with the chronic pain management program. Aside from the XX evaluation, there was a lack of information regarding the patient having completed a functional capacity evaluation to determine XX current XX demand level. There is also insufficient information pertaining to the full extent of the patient's conservative treatment in XX weeks and months to confirm that the patient had failed to respond to lower levels of treatment. While the XX sessions / XX hours would be within guidelines standards of care for this type of program, based upon the provided information, the current request cannot be authorized. As such, the request for Chronic Pain Management Program, XX sessions / XX units (XX times per week), related to a XX XX injury, as an outpatient is not medically necessary."

Per a utilization review decision letter dated XX, the prior denial was upheld by XX, XX. Rationale: "XX."

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

This patient has a chronic pain syndrome that is secondary to a XX injury back in XX. XX therapy has been extensive. The patient had XX XX surgeries and postoperative XX therapy. The patient was released to go back to work, but then returned because of recurrent symptoms. The patient has been seen by an orthopedist, XX anesthesiologists, a XX therapist and a XX. XX is still not fully rehabilitated and without further treatment, will unfortunately not be able to function as an employee or support XX.

A first utilization review in early XX XX cited the lack of lower levels of care and a functional capacity evaluation (FCE) However, an FCE was performed in XX XX noting that the patient had not returned to the "Medium Level" functional requirement of XX job, but was currently "Sedentary." With regard to the lack of lower levels of care

not being performed, this reviewer is in agreement that XX and/or affective XX medications have not been used in this patient. However, it is unlikely that at this juncture, these therapies in isolation will XX the patient's disability.

A second review in late XX XX stated "However, clarification is needed regarding recent non-operative treatment attempts. There was no clear indication that the patient had undergone an adequate and thorough multidisciplinary evaluation prior to the current request, addressing continued functional deficits. There was no clear indication that negative predictors of success had been identified." This patient has exhausted non-operative modalities. The patient does not has Complex Regional Pain Syndrome and regional anesthetic interventions are not indicated. The patient has had both an FCE, and XX evaluation. Negative predictors of success were discussed in detail in the XX assessment. Given the documentation available, the requested service(s) is considered 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 and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic XX 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 and Treatment Guidelines

  *ODG-TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines – Pain (updated XX)*

  *XX*
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

Case Number: ***XX*** Date of Notice: 02/20/19

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

**Appeal Information**

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.