

P-IRO Inc.

Notice of Independent Review Decision

Case Number: XX

Date of Notice: 5/10/2019 11:59:00 AM CST

P-IRO Inc.

An Independent Review Organization

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records – XX

- Physical Therapy Notes – XX
- Maximum Medical Improvement and Impairment Rating – XX
- Report of Medical Evaluations – XX
- Designated Doctor Examination – XX
- Functional Capacity Evaluation Summary – XX
- Behavioral Evaluation and Request for Services – XX
- Utilization Review – XX
- Appeal Letter – XX
- Peer Review Report – XX
- Diagnostic Data Reports – XX

PATIENT CLINICAL HISTORY [SUMMARY]: XXXX. XXXX is a XXXX-year-old XXXX with date of injury XXXX. XXXX was hit on the XXXX XXXX by a XXXX. XXXX had XXXX XXXX XX XX the XXXX XX. XXXX was able to free XXXX from the XXXX XX but had been having XXXX pain since then. XXXX was diagnosed with XXXX to the XXXX XXXX. XXXX. XXXX was seen by XXXX XXXX, MD on XX. On XX, XXXX reported the XXXX pain was constant and made worse by standing and walking. XXXX stated the pain at best was 4/10, and at worst, it was 10/10. On examination, XXXX. XXXX was XX XX. XXXX walked with a XXXX on the XXXX side. There was some XXXX and possibly some XXXX. On XX, XXXX. XXXX rated the XXXX XXXX pain at 7/10 with numbness and tingling. XXXX) unit was suggested in the meantime.

A functional capacity evaluation (FCE) was completed by XXXX, PT, on XX. XXXX. XXXX tested within the light physical demand category (PDC). Although XXXX tested with the light PDC, XXXX tested as to avoid XX and avoid XX negotiation, which were activities that XXXX reported needed to be able to perform XXXX regular job duties. During objective functional testing, XXXX. XXXX demonstrated consistent effort throughout 79.3% of this test, which would suggest XXXX. XXXX put forth full and consistent biomechanical and evidence-based effort during the evaluation. XXXX completed a series of tests and specific times for activities and weights for lifting were detailed in the report. Throughout objective functional testing, XXXX. XXXX reported reliable pain ratings XX.2% of the time which would suggest that the pain could have been considered a limiting factor during functional testing. During the evaluation, XXXX. XXXX presented with limiting factor(s) during objective functional testing, which included termination, compensatory techniques, stopping of the evaluator, general fatigue, increased pain, limited range of motion, and mechanical deficits. XXXX. XXXX was able to occasionally (0 to 33% of the time) lift 20 pounds, frequently (34% to 66% of the time) up to XX pounds, and constantly (37% to 100%) negligible amount.

A XX Evaluation was performed by XXXX , PhD, LPC on XX. Since the work-related injury, XXXX. XXXX' XX condition had been preventing XXXX from acquiring the level of XX needed to XX to the XX, XX the pain more effectively, and improve

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XXXX level of functioning. XXXX XX symptoms included XX -"XXXX;"XX ; XX XXX ; XX ; XX - "all the time XX ;"XX - "all the time XX;" increased XX ; become XX more easily; inability to get XX ; XX ; XX decrease; XX -" XXXX ;" feelings of XX -"XX;" XX; difficulties XX to injury; XX ; restlessness; rapid heart rate -"XX. XXXX. XXXX reported, "XX." XXXX. XXXX reported taking medication for XX and XX. XXXX had been taking XX medication since XX after XXXX work-related injury. XXXX reported taking medication for XX since XX due to XX issues. XXXX reported XXXX tried XX once in XX due to work issues. XXXX reported that XXXX did tend to XX XXXX and also reported XXXX had endured much XX XX in the XX from XXXX XX. XXXX reported that at the time, XXXX was not receiving any XX XX from Workers' Compensation, and that XXXX XX were very XX, and XXXX could not XX all of XXXX XX. XXXX reported that XXXX XX XX was "that XX XXXX is XX." On the Beck XX Inventory II (XX-II), XXXX. XXXX scored A XX and on the Beck XX Inventory (XX), XXXX scored a XX. On the Screener and XX Assessment for Patients in Pain-Revised (XX-R), XXXX scored Axx. On the XX XX Beliefs Questionnaire (XX), XXXX. XXXX scored 36 out of 42 on a work scale and 18 out of 24 on an activity scale. XX status examination showed a moderately XX XX with XX XX and an XX XX XX with XX. The XX seemed to be XX, and the affect was congruent to XX. XXXX. XXXX' self-reported tendency toward XX XX of XX, XX, and XX impaired future adjustment to employment. Individuals with this complex interplay of XX and XX symptoms tended to respond more favorably and rapidly to a multidisciplinary XXXX pain management program. The pain resulting from XXXX injury had severely impacted normal functioning physically and interpersonally. XXXX reported XX and XX related to the pain and pain behavior, in addition to decreased ability to manage pain. XXXX. XXXX reported XX XX resulting in all XX XX areas. It was noted XXXX would benefit from a course of pain management. It would improve XXXX ability to XX with the pain, XX, XX, and XX, which appeared to be impacting XXXX XX functioning. XXXX should be treated daily in a pain management program with both XX and XX modalities as well as medication monitoring.

XXXX XXXX x-ray dated XX showed no acute osseous or soft tissue abnormality.

An MRI of the xx dated XX demonstrated grade 3 stress response within the second and to a lesser degree fourth metatarsal bases without discrete fracture line.

The treatment to date included XX, XX, injections, and medications (XX,XX).

Per a utilization review dated XX, the request for 10 sessions / XXXX XXXX of the XXXX pain program three times per week was denied by XX, DO. Rationale: "Based on the documentation provided and per the Official Disability Guidelines, the requested 10 sessions / XXXX XXXX of the XXXX pain program 3 x a week is not medically necessary. Though the patient has a history of XXXX pain, there were no documentation of the patient having previously tried and failed all other conservative measures prior to the request. Per the Official Disability Guidelines, "Previous methods of treating XXXX pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement."

Per an appeal dated XX, Dr. XX and Dr. XXXX documented that the reviewer had denied XXXX. XXXX the XXXX pain management program. XXXX. XXXX was working on light duty at work at the time and wanted to get back to XXXX normal job title and duties. XXXX had been working for XX for XX years and would like to keep XXXX employment. At the time, XXXX. XXXX did not meet XXXX physical demand level (PDL) as stated on XXXX FCE, and was a requirement for the CPMP. XXXX. XXXX had also had pain injections and physical therapy, which were considered "previous methods" that were unsuccessful at bringing XXXX back or restoring XXXX to pre work injury function. The reviewer stated that no previous methods were tried, when in fact, they were tried. XXXX. XXXX scored moderate for XX, moderate for XX, high XX for XX XX, and XX XX XX for both work and physical activity. XXXX met ODG.

Per a utilization review dated XX, the request for 10 sessions / XXXX XXXX of the XXXX pain program three times per

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week was denied by XX MD. Rationale: "Previous methods of treating XXXX pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." In this case, a recent Designated Doctor examination recommended physical therapy per a XXXX protocol and sympathetic blocks. Although a history of unspecified "pain injections" is noted, there is no record of prior sympathetic blocks specifically. It is possible that additional physical therapy directed specifically to address CRPS, in conjunction with sympathetic blocks, could yield significant functional improvement. Thus, a XXXX pain program is premature and is not shown to be medically necessary at this time. Therefore, the appeal review of 10 sessions/XXXX XXXX of the XXXX pain program 3 times a week for the XXXX XXXX is not medically necessary."

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 10 sessions / XXXX XXXX of the XXXX pain program times three per week for the XXXX XXXX is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review dated XX, the request for 10 sessions / XXXX XXXX of the XXXX pain program three times per week was denied by XX, DO. Rationale: "Based on the documentation provided and per the Official Disability Guidelines, the requested 10 sessions / XXXX XXXX of the XXXX pain program 3 x a week is not medically necessary. Though the patient has a history of XXXX pain, there were no documentation of the patient having previously tried and failed all other conservative measures prior to the request. Per the Official Disability Guidelines, "Previous methods of treating XXXX pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." Per an appeal dated XX, Dr. XX and Dr. XXXX documented that the reviewer had denied XXXX. XXXX the XXXX pain management program. XXXX. XXXX was working on light duty at work at the time and wanted to get back to XXXX normal job title and duties. XXXX had been working for XX for XX years and would like to keep XXXX employment. At the time, XXXX. XXXX did not meet XXXX physical demand level (PDL) as stated on XXXX FCE, and was a requirement for the CPMP. XXXX. XXXX had also had pain injections and physical therapy, which were considered "previous methods" that were unsuccessful at bringing XXXX back or restoring XXXX to pre work injury function. The reviewer stated that no previous methods were tried, when in fact, they were tried. XXXX. XXXX scored moderate for XX, moderate for XX, XX XX for XX XX, and XX XX XX for both work and physical activity. XXXX met ODG. Per a utilization review dated 04/19/19, the request for 10 sessions / XXXX XXXX of the XXXX pain program three times per week was denied by XX MD. Rationale: "Previous methods of treating XXXX pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." In this case, a recent Designated Doctor examination recommended physical therapy per a XXXX protocol and sympathetic blocks. Although a history of unspecified "pain injections" is noted, there is no record of prior sympathetic blocks specifically. It is possible that additional physical therapy directed specifically to address CRPS, in conjunction with sympathetic blocks, could yield significant functional improvement. Thus, a XXXX pain program is premature and is not shown to be medically necessary at this time. Therefore, the appeal review of 10 sessions/XXXX XXXX of the XXXX pain program 3 times a week for the XXXX XXXX is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records fail to establish that this patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no documentation of injection therapy for treatment of CRPS. It is unclear if the patient has undergone a course of individual psychotherapy.

Given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence based guidelines and therefore the decision is upheld.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Pain: XXXX pain programs (functional restoration programs)