Becket Systems
An Independent Review Organization
3616 Far West Blvd Ste 117-501 B
Austin, TX 78731
Phone: (512) 553-0360
Fax: (512) 366-9749
Email: @becketsystems.com

Notice of Independent Review Decision
Amendment X
Amendment X
Amendment X

IRO REVIEWER REPORT
Date:X;X;X;X
IRO CASE #: X
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:

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

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X
PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was status

post radial head fracture on X. The diagnosis was complex regional pain syndrome, chronic pain syndrome, and long term (current) use of opiate analgesic. On X, X was evaluated by X, MD for a follow-up visit of status post radial head fracture. At that time, X was status post-surgery and physical therapy (PT). X had increased pain in entire arm, sensitive to touch and not responsive to over the counter (OTC) medicines. The pain was a burning which was worse with touch and movement, the site was well healed. X reported that there were times of color changes and swelling. There was some weakness reported in the initial visit. X had not been working secondary to dysfunction. X presented with early complex regional pain syndrome (CRPS) signs / symptoms of left arm from fracture sustained at work on X. There was no surgical option at that time and treatment would be X. On examination, X blood pressure was 131/93 mmHg, weight was 159 pounds and BMI was 28.2 kg/m2. Cervical spine examination revealed strength of 3+ in the left biceps and left triceps, and strength was 4 in the left wrist flexion and left wrist extension. The left-hand intrinsic strength was 4. Left upper extremity (LUE) dermatomal sensation revealed + allodynia of left arm. Dr. X assessed that X was a candidate for multimodal therapy. The treatment plan would include therapy, BMI optimization, bracing, medication management, and interventional therapy which may include epidural steroid injections (ESIs) for radicular symptoms with imaging revealing disc displacement or stenosis / spondylosis, medial branch blocks (MBBs) / radiofrequency ablations (RFAs) for axial spine pain, joint injections / blocks for articular pain, ganglion / nerve blocks for sympathetically mediated / neuropathic pain, and trigger point injections for myofascial pain. The severe chronic debilitating pain that was refractory to conservative measures would be evaluated / treated with advanced imaging, surgical consultation, and / or spinal cord / peripheral nerve stimulation, as indicated. X suffered from chronic pain which affected X ability to perform activities of daily living and impaired X quality of life. X reported functional benefit with an opioid regimen and was able to maintain activities of daily living. Regarding CRPS, left stellate ganglion block with sedation was recommended. X had following Budapest Criteria at the time of visit: continuing pain and disproportionate to inciting event. X reported of hyperesthesia and / or allodynia, skin color changes or temperature and / or skin color changes between the limbs, edema and / or sweating changes, decreased range of motion and / or motor dysfunction and / or trophic changes. Treatment to date included medication (X. Per a peer review report / utilization review adverse determination letter dated X

by X, MD, the request for X was denied. Rationale: “The ODG supports sympathetic blocks only as a last option for limited select cases as a therapeutic adjunct facilitate physical therapy/functional restoration. The records provided do not clearly document objective findings on physical exam that fulfill the Budapest criteria. Moreover, there is no mention of trial and failure of cognitive behavioral therapy and motion exercises since the onset of the neuropathic complaints and findings described in the records. Therefore, based on the information available, the request is not shown to be supported by the ODG nor otherwise medically necessary. “Per a reconsideration / utilization review adverse determination letter dated X by X, MD, an appeal request for X was denied. Rationale: “Per ODG, "Sympathetic block may only be considered as a last option for limited, select cases with a diagnosis of sympathetically mediated pain and as a therapeutic adjunct to facilitate physical therapy / functional restoration… (4) Therapeutic use of sympathetic block is only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled (See #1-3). These blocks are only recommended if there is evidence of lack of response to conservative treatment including pharmacologic therapy, physical rehabilitation, and psychological assessment. In this case, the claimant complains of increased burning pain, color changes, swelling, and weakness in the right arm. Physical examination revealed 3+/5 strength of the left biceps and triceps, 4/5 strength of the left hand intrinsic and left wrist flexor and extensor, and allodynia in the left arm. Treatment history included physical therapy and medications, however, there is no documentation of a psychological assessment. As such. the request is deemed not medically necessary and is not certified. “Thoroughly reviewed supplied documentation including provider notes and peer reviews. Patient may be experiencing signs of CRPS in left upper extremity based on history and exam. However, provider’s primary diagnosis is generic “chronic pain syndrome” and lists multiple potential interventions considered such as MBBs/RFAs, ESIs, other injections. CRPS is listed as the third problem for this patient. Budapest criteria is referenced and is reflected in exam (unlike what 1st peer review believes).However, both peer reviews refer to ODG criteria, which recommend sympathetic blocks such as a X as a last resort - only after failure of pharmacologic therapy, physical rehabilitation, and psychological assessment. It does not appear these have been done yet to warrant last resort of X. X is not medically necessary and non certified

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

Thoroughly reviewed supplied documentation including provider notes and peer reviews. Patient may be experiencing signs of CRPS in left upper extremity based on history and exam. However, provider's primary diagnosis is generic "chronic pain syndrome" and lists multiple potential interventions considered such as MBBs/RFAs, ESIs, other injections. CRPS is listed as the third problem for this patient. Budapest criteria is referenced and is reflected in exam (unlike what 1st peer review believes).However, both peer reviews refer to ODG criteria, which recommend sympathetic blocks such as a X as a last resort - only after failure of pharmacologic therapy, physical rehabilitation, and psychological assessment. It does not appear these have been done yet to warrant last resort of X is not medically necessary and non certified
Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**