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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 Overturned 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 working as a X. The diagnosis was status post work injury with a partial thickness right medial gastrocnemius tear. On X, X, MD ordered an initial request for X. Dr. X stated that on X, X was working as a X. X was evaluated at X where X was recommended X. A X demonstrated X. X was returned back to work with restrictions. On X, Dr. X provided a X. X completed a course of X. X had right leg pain, functional deficits, and a secondary clinical depressive reaction. Treatment provided included X. The average pain level was X, PAIRS was X, BDI was X, BAI was X, and GAP was X. X had pain disorder associated with both psychological factors and a general medical condition and major depression, moderate. A functional capacity evaluation (FCE) demonstrated X functional performance at the sedentary physical demand level (PDL). Dr. X recommended a X. X sustained a X. Treatment with X had been provided. Other lower level of treatment intervention had been exhausted. X did not have adequate pain and X was needed to so that they may be functional while dealing with constant pain on a daily basis. X needed to learn alternative methods of controlling pain and diminish dependence on the X. X had significant functional deficits and required assistance with regular activities of daily living. Functional activities exacerbated the pain, rendering X incapable of tolerating sustained activity. Significant X was required. Per conclusion, Dr. X stated that X required the medical services that were only available in a X. Dr. X requested reconsideration for X as it was denied. On X, X was seen by X, MD for right leg pain. X sustained an injury to X right lower extremity on X when X was X. X had noticed swelling in the right knee. On the ongoing day, X rated the leg pain X. X had taken X on an as needed basis. X had completed approximately X. X was initially on light duty and was terminated in X. Initially, X wore a X. X had right lower extremity pain at rest, at night, and during the day with any type of prolonged standing or walking activities. X stated that X right lower extremity was asymptomatic prior to X work injury. On examination, X weight was 233 pounds. X was in mild distress. X ambulated with a stiff legged,

short-stepped gait on the right with an ankle brace in place. X had full extension and X degrees of knee flexion actively. X knee was stable to varus and valgus stress testing at X and X degrees. X had tenderness to palpation at the X. Passively, X had X and X degrees of passive ankle plantar flexion. X had X degrees of passive foot inversion and eversion. X had X resisted ankle dorsiflexion and plantar flexion strength. X had X resisted foot inversion and eversion strength. An MRI report of the right tibia and fibula dated X revealed X. A venous Doppler ultrasound report of the right lower extremity dated X revealed X. The plan was to continue. According to a Preauthorization Request note dated X, Dr. X requested treatment of X. Dr. X stated that the medical necessity for the X had already been established. X was participating in the program, and X was demonstrating progress, achieving improved levels of X. BDI improved from 21 to 17 and functional performance from sedentary to sedentary-to-light PDL. X could demonstrate the upcoming progress. X was expected to build the pain management skills, eliminate daily use of pain medication, and complete X vocational counseling. X progression had not plateaued, and X was expected to achieve X program goals if provided the opportunity; therefore, it was unreasonable and counterproductive to terminate X treatment at the time. With consideration of this information, Dr. X would request authorization for an additional X for X. Per Texas Labor Code Section X, Entitlement to Medical Benefits, X was entitled to the proposed treatment as this would promote recovery, enhance X ability to return-to-work, promote maximum medical improvement, and promote case resolution. In conclusion, Dr. X stated that Mr. X required the medical services that were only available in a X in order to address the psychological component of X injury, achieve clinical MMI, return to gainful employment, and to achieve case resolution. Medical necessity for the X had already been demonstrated, X was participating in the X, and X was demonstrating progress. On this basis, they would request reconsideration for X for X. Treatment to date included X. Per a utilization review adverse determination letter and peer review report by X, DO, the request for X was non certified on X. Rationale: “Per the MD and the notes provided, X has had no change in pain score or med use despite X. X current PDL is sedentary/light which has only improved by one-half a level, X BDI went from X to X. AII these changes are minimal to none so continuation of the pain program is not supported. Therefore, the request for X is not medically necessary.” A Preauthorization Request note dated X indicating Dr. X requested a reconsideration for denied

treatment of X. Dr. X stated that the medical necessity for the X had already been established. X was participating in the program, and X was demonstrating progress, achieving improved levels of X. BDI improved from X to X and functional performance from sedentary to sedentary-to-light PDL. X could demonstrate the upcoming progress. X was expected to build the pain management skills, eliminate daily use of pain medication, and complete X vocational counseling. X progression had not plateaued, and X was expected to achieve X program goals if provided the opportunity; therefore, it was unreasonable and counterproductive to terminate X treatment at the time. With consideration of this information, Dr. X would request authorization for an A X for X. Per Texas Labor Code Section 408.021, Entitlement to Medical Benefits, X was entitled to the proposed treatment as this would promote recovery, enhance X ability to return-to-work, promote maximum medical improvement, and promote case resolution. In conclusion, Dr. X stated that X required the medical services that were only available in a chronic pain management program in order to address the psychological component of X injury, achieve clinical MMI, return to gainful employment, and to achieve case resolution. Medical necessity for the chronic pain management program had already been demonstrated, X was participating in the chronic pain management program, and X was demonstrating progress. On this basis, they would request reconsideration for X for X. Per a reconsideration review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “ODG guidelines do not recommend total X unless there is supportive documentation and individualized care plan is submitted. The data submitted does not have the supporting evidence. Claimant appears to be plateaued with the current program. A X should be considered. Therefore, the request is not medically necessary. “According to a letter dated X, Dr. X documented that X had demonstrated improvement with treatment in the X thus far, achieving improved levels of X. Over the course of X treatment, X condition had improved and X was no longer X, and as X,X had improved. X,X had also improved. X had decreased use of X functional output in the functional restoration portion of the program. Our purpose in providing this program was also to extinguish X regular use of medications and dependence on the healthcare team. Although X had improved, X needed additional time to complete this process. With consideration of the following extenuating circumstances, they requested authorization for the remaining hours of the X for X as was recommended per the guidelines. The medical necessity of the X had already

been established and at the time, X must complete X. The carrier had denied access for X to complete the program; therefore, they requested an authorization of X for X, so that X may achieve X program goals and case resolution. Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter and peer review report by X, DO, the request for X was non certified on X. Rationale: "Per the MD and the notes provided, X has had no change in pain score or med use despite X. X current PDL is sedentary/light which has only improved by one-half a level, X BDI went from X to X. AII these changes are minimal to none so X is not supported. Therefore, the request for X is not medically necessary." Per a reconsideration review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: "ODG guidelines do not recommend total X hours unless there is supportive documentation and individualized care plan is submitted. The data submitted does not have the supporting evidence. Claimant appears to be plateaued with the current program. A X should be considered. Therefore, the request is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is minimal progress documented with the X completed to date. The note dated X indicates that X reported pain level is X. BDI minimally decreased. The patient's PDL increased only from sedentary-to-sedentary light. There is a lack of documentation of significant and sustained improvement. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Additional 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter and peer review report by X, DO, the request for X was non certified on X. Rationale: "Per the MD and the notes provided, X has had no change in pain score or med use despite X. X current PDL is sedentary/light which has only improved by one-half a level, X BDI went from X to X. AII these changes are minimal to none so X is not supported. Therefore, the request for X is not medically necessary." Per a reconsideration review adverse determination letter and peer

review report dated X by X, MD, the request for X was denied. Rationale: “ODG guidelines do not recommend total X unless there is supportive documentation and individualized care plan is submitted. The data submitted does not have the supporting evidence. Claimant appears to be plateaued with the current program. A X should be considered. Therefore, the request is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is minimal progress documented with the X completed to date. The note dated X indicates that X reported pain level is X. BDI minimally decreased. The patient’s PDL increased only from sedentary-to-sedentary light. There is a lack of documentation of significant and sustained improvement. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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

☐ 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

☐ TMF SCREENING CRITERIA MANUAL