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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 Overtuned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who reported X had an injury on X when X. The diagnosis was right foot pain. On X, X underwent a behavioral evaluation by X, MA, NCC and X, PhD, LPC-S. It was noted that the pain resulting from X injury had severely impacted normal functioning physically and interpersonally. X reported X. Pain had reported high stress resulting in all major life areas. X would benefit from a course of pain management. It would improve X ability to cope X. X should be treated daily in a X. The program was staffed with X. The program consisted of but was not limited to X. These intensive services would address the current problems of X. X underwent a X evaluation by X, PT, on X. The purpose of evaluation was to determine X. X demonstrated the ability to perform X of the physical demands of X job as a X. Consistency of Effort results obtained during testing indicated significant observational and evidence-based inconsistencies resulting in self-limiting behavior and submaximal effort. Reliability of Pain results obtained during testing indicated X functional pain reports were X. X demonstrated the ability to perform within the X. Based on X. It should be noted that X was classified within the MEDIUM Physical Demand Category. X lifted X pounds to below waist height. X lifted X pounds to shoulder height and X pounds overhead. X carried 0 pounds. Pushing abilities were evaluated and X pulled 0 horizontal force pounds and pushed 0 horizontal force pounds respectively. Non-material handling testing indicated X demonstrated an occasional tolerance for Above Shoulder Reach, Bending, Pinching, Simple Grasping and Standing. X demonstrated the ability to perform Forward Reaching and Fine Coordination with frequent tolerance, Sitting were demonstrated on a constant basis. The functional activities X should avoid within a competitive work environment included X. It should be noted safety concerns exist for this patient when X. These activities were stopped by the evaluator and should be avoided. Per a Physician Progress Report by X, MD dated X, X was re-evaluated for X work-related injury sustained on X. X reported still having severe pain in the right lower extremity in the foot and the knee. It was rated X and was constant. Nothing helped it and nothing made it worse. X knees buckled. X stated X was following the treatment plan, but it was not helping. X was on X that did not really help. X

had X sessions of X. Injections had not been done. MRIs had not been done, however, had been done on the foot. Examination noted X to be X. X used a X. There was X. X was X. X walked with an X. The assessment was right foot pain. at that point, they were awaiting a chronic pain program approval after which X would be at MMI in Dr.X' opinion. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD as not medically appropriate. Rationale: "Per ODG "Recommended where there is access to programs with proven successful outcomes (ie, decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery" In this case, the claimant presented with right foot pain. The documentation does not substantiate the claimant underwent an x. Hence, request is denied. Recommend noncertification. Per an appeal letter dated X, by X, MA, NCC, X, PhD, LPC-S, and X, MD, the reviewer denied X the X. The behavioral / psychiatric examination was done on X and the functional capacity evaluation was done on X, in which both showed that X was a candidate for the program. Per a reconsideration review adverse determination letter dated X, the request for an appeal for X was denied by X, DO. Rationale: "The Official Disability Guidelines recommend X"Delayed recovery." On X, the claimant had a follow-up office visit with complaints of a right leg pain and left knee pain. The claimant reported that it gets swollen and can hardly walk sometimes. Conservative treatments to date were X. The functional capacity evaluation dated X reported that the claimant demonstrated ability to perform X. However, the submitted summary of the treatment plan is not detailed and individualized enough to correspond to the claimant's functional disability noted in the functional capacity evaluation (FCE) report. The nature and frequency of the services to be included in the program as well as the duration were not highlighted. I called today at X and spoke with X. X stated the behavioral evaluation records has the claimant's goals for the program. X also stated that the program is X days a week from X for X weeks. However, X was unable to provide the nature and frequency of the services to be included in the program. Hence, the noncertification is upheld. Thus, the request for X is noncertified. Thoroughly reviewed provided records including peer reviews. Patient with development of pain issues related to right foot for over X year. Providers considering referral to X. The patient has had some X. Other treatment options need to be considered. Initial peer review noted that patient does not appear to have adequate evaluation for a X. On the other hand, the initial review

does note that the person they spoke to was unable to specify the specific nature of their program as well as frequency of services (but they also said it was X days a week). However, despite this issue, the patient does appear to meet the cited ODG criteria from these peer reviews for the requested program. X is medically necessary and certified

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

Patient with development of pain issues related to right foot for over X year. Providers considering referral to X. The patient has had some X. Other treatment options need to be considered. Initial peer review noted that patient does not appear to have X. On the other hand, the initial review does note that the person they spoke to was unable to specify the specific nature of their program as well as frequency of services (but they also said it was X days a week). However, despite this issue, the patient does appear to meet the cited ODG criteria from these peer reviews for the requested program. X is medically necessary and certified
Overturned

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)**