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Notice of Independent Review Decision

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 sustained an injury on X. At work, X. X worked for approx five minutes, but the pain increased. X sat in the break room for the remainder of X shift. The diagnoses included strain of muscle and tendon of unspecified wall of thorax. X was seen by X, MD on X for a follow-up on X. X was off work. X rated X pain X. Approval for X was pending. X felt about the same since the prior visit. X was unable to work. the pain was intermittent and constant. Bending and twisting made the pain worse. The pain was better by resting. X reported that X was following the treatment plan, but it was not helping. X was on X, which had helped somewhat, but not majorly, X received X without any improvement. On examination, X. There was X noted. Functional Capacity Evaluation was performed on X by X, PTA /X, MD to determine X overall musculoskeletal and functional abilities as it related to the physical demands outlined by the X. The job-specific evaluation was performed in a X and X demonstrated the ability to perform X of the physical demands of X Job as a X. The return to work test items X was unable to achieve successfully during this evaluation included occasional squat lifting, occasional powerlifting, occasional bilateral carrying, occasional pushing, occasional pulling, bending, kneeling sustained, kneeling repetitive, crawling, walking, ladder/other, static balance up off of the ground, dynamic balance up off of the ground, sitting and standing. X demonstrated the ability to perform within the LIGHT Physical Demand Category based on the definitions developed by the X, which is below X jobs demand category. Based on sitting and standing abilities, X may be able to work full-time within the functional abilities outlined in this report. It should be noted that X job as a X is classified within the HEAVY Physical Demand Category. During objective functional

testing, X demonstrated consistent effort throughout X of this test which would suggest X presented with segmental inconsistencies during this evaluation resulting in mild self-limiting behaviors/sub-maximal effort. During this test, the items that were inconsistent included right five-span grip inconsistencies, left five-span grip inconsistencies, right five-span versus right grip inconsistencies, left five-span versus right grip inconsistencies and biomechanical inconsistencies during floor to waist lifting. Throughout objective functional testing, X reported reliable pain ratings X of the time which would suggest that pain could have been considered a limiting factor during functional testing. During the evaluation, X was unable to achieve X of the physical demands of X job/occupation. The limiting factor(s) noted during these objective functional tests included compensatory techniques, evaluator stopped, general fatigue, increased pain, loss of balance, mechanical deficits, poor posture, safety concerns, and substitution patterns. On X, X visited Dr. X for a follow-up of a X. X felt worse, sharp, burning pain, rated X, which was intermittent. It was made worse by twisting and bending. It was better by resting and lying down. X reported no new symptoms. X was following the treatment plan, but it was not helping. X was on X, which helped a little bit. X had several sessions of X without any improvement. X stated X had not helped. X had been approved. On examination, flexion, extension, rotation of lumbosacral spine decreased X to X in all planes. Pain on X was noted. There was a X. An MRI of the thoracic spine was performed on X for back pain. It showed X. CT scan of the abdomen and pelvis on X revealed X. X-rays of the right ribs on X showed no acute fractures. Treatment to date included X. Per the utilization review by X, MD on X, the prospective request for X was non-certified. Rationale: “Regarding the X, the Official Disability Guidelines state that it is recommended prior to considering X. This X is not recommended in the X. No more than one set of X should be performed prior to X. The guideline states the criteria for the justification of the medical necessity including the absence of X. No more than X. X is only to be considered

for extreme patient anxiety. It appears this request is not supported by guidelines at this time based on the provided documentation. The claimant has thoracic pain rated as X. Multiple conservative measures were not helping. The cited guideline does not recommend X. Hence, request is not supported. This request was non-certified in X. Therefore, the request for X is non-certified. “Per the utilization review by X, MD on X, the request for the prospective request for X was non-certified. Rationale: “The prior request for X which was non-certified by Dr. X based on the fact that the guideline does not recommend X. Per the email dated X, a request for an appeal was received. According to the submitted documentation, the claimant sustained an injury when a X. The claimant was diagnosed with a strain of muscle and tendon of the thorax, chest pain, low back, coccyx, and thoracic spine pain, muscle spasms, and a strain of the lumbar region, coccyx, sacrum, shoulder, and thoracic region. The claimant was unable to work. Prior treatments included X. They followed the treatment plan, which was not helping. An MRI of the thoracic spine dated X revealed X. Per the progress report dated X and submitted by X, M.D., the claimant had thoracic pain rated at X, worsened with bending and twisting. The examination revealed rotation of the thoracic spine was painful at X degrees bilaterally. There was X. Regarding the X, the Official Disability Guidelines (ODG) state that it is recommended prior to considering X and is the preferred procedure to determine facet-mediated pain. This X is not recommended in the X. No more than X. The guideline states the criteria for the justification of the medical necessity including the absence of X. No more than X. X is only to be considered for extreme patient anxiety. Based on the submitted documentation, the prior request for X which was non-certified by Dr. X was appropriate. The claimant has presented with severe thoracic pain despite various conservative measures rendered. Also, the guidelines state that the X is not recommended in the X. Furthermore, the submitted documents do not contain the provider's reason/rationale for the appeal. In this case, proceeding with the

requested X remains inappropriate. Therefore, the requested appeal for X is non-certified. “Based on the submitted documentation, the requested procedures are not medically necessary or appropriate. The guidelines do not support X. No new information has been provided which would overturn the previous denials. Recommend prospective request for 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 submitted documentation, the requested procedures are not medically necessary or appropriate. The guidelines do not support X. No new information has been provided which would overturn the previous denials. Recommend prospective request for 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)**