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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:

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. X

reported the X. X reported X. The diagnosis was left shoulder strain, left acromioclavicular separation type 3, status post left shoulder arthroscopic repair, cervical sprain / strain, and synovitis and tenosynovitis of the left arm. On X, X underwent a Behavioral Evaluation and Request for Services (Request for X) by X, MA, X, PhD, and X, MD. In summary, it was noted that the pain resulting from X injury had severely impacted normal functioning physically and interpersonally. X reported frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. X 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 with pain, anxiety, frustration, and stressors, which appeared to be impacting X daily functioning. X should be treated daily in a pain X. The program was staffed with multidisciplinary professionals trained in treating chronic pain. The program consisted of, but was not limited to daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management, and vocational counseling as well as physical activity groups. These intensive services would address the ongoing problems of coping, adjusting, and returning to a higher level of functioning as possible. X underwent a functional capacity evaluation (FCE) by X, PT on X. This job specific evaluation was performed in a X approach and X demonstrated the ability to perform X. The return to work test items X was unable to achieve successfully during this evaluation included: occasional squat lifting, occasional power lifting, frequent power lifting, occasional shoulder lifting, frequent shoulder lifting, occasional overhead lifting, occasional bilateral carrying, occasional unilateral carrying, occasional pushing, occasional pulling, gross motor coordination, fine motor coordination, simple grasping, firm grasping, pinching, bending, squatting, sustained squatting, kneeling sustained, kneeling repetitive, crawling, walking, forward reaching, above shoulder reaching, ladder/other, static balance up off of the ground, dynamic balance up off of the ground and sitting. X demonstrated the ability to perform within the sedentary physical demand category based on the definitions developed by the US Department of Labor and outlined in the Dictionary of Occupational Titles, which was 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. 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 left hand grip strength inconsistencies, left five span grip inconsistencies, left five span versus right grip inconsistencies and left hand pinch strength inconsistencies. X reported light headedness, dizziness, and a high pain level throughout the evaluation and expressed desire to complete it entirely. X performed exercises with limiting factors: increased pain, safety concern, loss of balance, evaluator stopped, mechanical deficits, and limited range of motion. During this 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: evaluator stopped, increased pain, limited range of motion, loss of balance, mechanical deficits and safety concern. X, MD saw X on X for the diagnosis of synovitis and tenosynovitis, unspecified. X felt about the same with dull, sharp pain, pins and needles, X pain. X was able to do X of X job. Walking and sitting down made the pain worse. Nothing made it better. X was following the treatment plan, but it did not help. X took X for pain, X for X headaches, with no improvement. X had received X. Musculoskeletal examination showed reproducible chest pain. Cervical range of motion was with decreased flexion, extension, and rotation weightbearing approximately X to X in all planes. X were noted at X. The assessment was cervical sprain, strain. X was denied the X. The denial would be appealed. On X, X was seen by X, MD for a X. X continued to have a positive Finkelstein test and also had achy pain throughout the entire left arm, but most of the pain was over the first dorsal compartment. The X. X tolerated the procedure well.Treatment to date included X. In an appeal letter dated X, by X, MA / X, PhD, X, MD, documented, “Reviewer denied X the X based on no documentation of first line treatment for X work related injury. Patient has had an X. X has also had surgery on X shoulder for this work related injury. Patient has seen specialists listed on page 1 of the Behavioral Evaluation dated X. X reports high pain levels and difficulty managing X pain day to day and X pain is considered Chronic as X injury is over a year. Patient is also taking pain medication and has had other pain medication in the past with little or no relief X scored High Fear Avoidance as shown on page 4 of the Behavioral evaluation which the chronic pain management program will help to decrease X fears and increase X function with X work related injury. Patient reports X wants to go back to work. Patient will benefit from this functional restoration program which incorporates counseling

and exercises to obtain the quickest results. The program uses CBT. Please see attached records of treatment. Patient meets ODG."Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO. It was determined that the request still did not meet medical necessity guidelines. Rationale: "Regarding the chronic pain program, the ODG states that chronic pain programs for the neck are recommended. Interdisciplinary functional restoration programs (FRPs) are equally efficacious for treating both chronic occupational cervical and lumbar disorders, and FRPs are equally effective, irrespective of the compensable body part(s). In this case, the examination revealed X. The pain was associated with numbness and tingling in the upper extremities. The claimant was treated with X. The ODG recommends a X. There is a lack of documentation of treatment for the claimants psychological issues or of failure of any other therapies other than PT. Exhaustion of all conservative modalities cannot be determined. Therefore, medical appropriateness has not been established, and the request for a X is non-certified. Peer to peer was unsuccessful."Thoroughly reviewed provided records including provider notes and peer reviews. Patient had extensive prior management including X. They had a full evaluation including with behavioral health specialist before request for X. The request meets the cited ODG criteria as detailed in X appeal letter. X is medically necessary and certified

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

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient had X. They had a full evaluation including with behavioral health specialist before request for X. The request meets the cited ODG criteria as detailed in X appeal letter. 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)**