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Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT

Date: X: Amendment X: Amendment 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)

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 walked X. X X. The diagnoses were trigger right middle finger, nondisplaced fracture of body of hamate bone of right wrist, and traumatic rupture of right ulnar collateral ligament. A Treatment Progress Report was documented on X by X, MS, LPC-S / X, MS, LPC. X continued to follow-up with X treating physicians for ongoing medical care and treatment recommendations. On Patient Pain Drawing, X rated X overall pain as X, a decrease of X point, indicating moderate to severe pain. X reported aching pain in X right arm and hand. On the Pain Experience Scale, X scored a X, an increase of X points, indicating moderate amounts of emotional distress when X pain was at its worst. X 'often' felt frustrated, irritable, overwhelmed, and anxious. On the McGill Pain Questionnaire, X scored a X, a decrease of X points, indicating normal pain episodes. X described X sensory/sensation reaction as: hurting. X had affective emotional reactions as: exhausting. X evaluation/judgement reactions were nagging. X pain frequency was often. X pain severity was distressing. On the Fear Avoidance Beliefs Questionnaire, X scored X, an increase of X points, in the Physical Sub Scale and X in the Work Sub Scale, an increase of X points. These scores were suggestive of elevated levels of avoidance and fear related to X work-related injury and the impact of the pain on X current level of physical functioning. On the Quality-of-Life Scale, X rated X at a X, a decrease of X point, (O=non- functioning; X =normal). X worked and volunteered for limited hours, took part in limited social activities on weekends. On the Beck Depression Inventory, X scored a X, a decrease of 3 points, indicating mild/moderate depression. X reported problems with loss of libido, work difficulty, insomnia, and somatic preoccupation. On the Beck Anxiety Inventory, X scored a X, an increase of X point, indicating mild levels of anxiety. X reported problems with unable to relax, heart pounding or racing, fear of the worst happening, nervous, and scared. On the Sleep Questionnaire, X scored a X, a decrease of X points, indicating mild sleep disturbances. X 'almost always' had a problem with trouble falling asleep, waking up during sleep, sleep did not seem refreshing, and waking up too early in the morning. X attributed X sleep problems to physical, too restless and tense, stress, frustration, and anger. X had trouble sleeping X nights a week and averaged X hours of sleep each night. It took X about X hour to fall asleep and X woke up X times during the night. X stated that after

awakening it took X a long time to fall back to sleep. X did not take any medication to help X sleep. On the Disabilities of the Arm, Shoulder, and Hand Questionnaire, X scored at X, (unchanged) an increase of X, indicating a crippling perception of disability and functioning. The pain impinged on aspects of X life both at home and at work. X reported being 'unable' to open jars or doors and had 'severe difficulty': doing household chores/ yard work, carrying objects, washing/drying X hair and back, using a knife to cut food and participating in recreational activities. X reported X problem interfered with X normal social activities and regular daily activities 'quite a bit'. X rated the severity of X problem as extreme and had difficulty sleeping. X felt less capable and less useful because of X problem. X was not taking any medications at the time. X had received X sessions of X. During this treatment phase, X attended all X appointments. X reported ongoing pain had caused X to suffer from depression and anxiety as X had not been able to complete adult daily living tasks efficiently. X had complied with all recommendations made by X providers but found it very difficult at times to cope during times of extremely painful episodes. They also discussed X. X had difficulty incorporating hobbies of interest in X life due to lack of satisfaction and little to no motivation. Therapist addressed these symptoms by collaborating with X on what helped to reduce these symptoms. With all of the above mentioned, continuation of X was highly recommended at this time for X to support in these areas of medical treatment planning, case management, monitoring of medications, pain management and affective symptoms, and psychosocial stressors related to X work injury. Therapist and X would continue to work collaboratively on identifying positive coping skills that had worked for X in the past and building upon those. In fact, utilizing these coping skills when new unforeseen circumstances that caused stress or anxiety symptoms to arise. Therapist and X were also engaged in problem solving during sessions, and X presented to following sessions as having implemented what X learned during past sessions. They would continue to work on building self-confidence and independence. The therapist and X would brainstorm ways to manage and repair family structure and build family support and relationships. X reported being dependent on X family, which caused X stress because X had always worked and never needed help from others. They would continue to address these issues and help navigate through the process. X expressed high interest in continuing X to work on the severe symptoms of anxiety, depression and sleep. Dr. X had recommended that X continue X participation in X to address vocational / case

related needs, depression, anxiety and sleep symptoms that had arisen due to the work injury. X consulted X, LPC-S / X, MS, LPC on X for a follow-up. X continued with anxiety, depressed mood, hopelessness, irritability, loss of interest, low energy, mood lability, poor concentration, racing thoughts, sleep disturbance and worthlessness. X presented with adequate cognitive ability to establish a therapeutic relationship with clinician. There was a likelihood that X behavior would improve in response to participation in therapy. X complained of worrying about things too much, feeling tense, anxious, nervous, or shaking, phobias, chronic pain, depressed mood, feeling down or blue, irritable, crying easily, feeling easily hurt, feeling hopeless about the future, thoughts of hurting self, thoughts about death or dying, physical functioning limitations, sleep disturbance, trouble falling asleep, restless sleep, waking too early and being unable to fall back asleep or sleeping too much. X condition had improved since the prior session. On the mental status examination, X presented it as fair. X was anxious, depressed, and worried. X mood was presented as anxious. X thought process was presented as flight of ideas, intact, and logical. X had a full memory recall. X judgment was good. X presented with good insight. X was alert and oriented times X. X denied suicidal or homicidal ideation. X presented with improving coping ability. X speech patterns were rapid. X behavior presented as apparent distress and engaged. X reported no change in ongoing stressors or symptom severity. X had normal attention. X impulse control was fair. X psychomotor activity was presented within normal limits. X confirmed sleep disturbances. X psychosocial stressors and risk factors included chronic pain economic problems due to financial difficulties, issues with disability support payments, emotion, physical functioning limitations, isolation, and occupation problems related to workplace disputes. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DC, the request for Quantity: X was noncertified. Rationale: “Recommend non approval and non-certification of the services as submitted. The ODG would not support the X. The patient has undergone X. A peer-to-peer conversation was attempted on two separate occasions for clarification of X. Medical necessity was not established as recommended by the Official Disability Guidelines. “A response to denial letter was documented on X by X, MS, LPC-S, The letter indicated “X on X requested X, which was denied on X. X is appealing this decision which was deemed denied due to the following reasons: "Determination: Recommend non approval and non-certification of the services as submitted. The ODG would not support the X. The

patient has X. A peer-to-peer conversation was attempted on two separate occasions for clarification of X. Medical necessity was not established as recommended by the Official Disability Guidelines." There are several items which need to be clarified in addressing this denial of the requested X. First, our office attempted to call the physician advisor for the peer to peer however was not successful, so we missed our opportunity to discuss our rationale, please accept this letter of appeal for reconsideration. As summarized in the Treatment Progress Report (TPR) submitted (dated X) upon review of medical records used for this report from X doctors' office, Dr. X., DC., X has been working and in the latest follow up of X, Dr. X noted X had to decrease X work hours to X a week, due to severity of neck, back, and right wrist complaints. X expressed moderate frustration, anxiety, and depression due to duration of symptoms, lack of long-term pain relief and limited function. Dr. X' primary treatment plan was for X to maintain a modified work duty, daily home exercises, medications (p.r.n.) and to follow up in X days. With respect to the above medical information documented and psychological goals clarified in our report submitted, we are making every effort to establish medical necessity to proceed with our request for X. This treatment team recommends that X have an opportunity to attend X. Therapist will continue to aid in maintaining focus on X medication compliance, medical care, vocational/work stress, case management needs, monitoring affective symptoms, and the importance of maintaining a healthy leisure balance with X family and close relationships. Literature supports there are six major patient variables that include social support, problem complexity and chronicity, personality reactivity and coping styles and treatment setting. Next, it is evident X has chronic pain resulting from X injury date of X. X has participated in X since X Initial Diagnostic Interview completed in X. We understand that X may soon be outside Official Disability Guidelines (ODG), further defined below, however X has had meaningful progress throughout X individualized counseling services with our office and medical care to date. X has the following accepted medical diagnoses: X. “Per a reconsideration review adverse determination letter dated X by X, DC, the request for Quantity: X was noncertified. Rationale: “Recommend denial and non-certification of the services requested. Based on X orthopedic consultation, the patient is not surgical. It does not appear that this patient has returned to work. Unable to determine how many sessions of X. X progress report notes X. This progress note demonstrates significantly declining FABQ sub scales including a pain experience scale and Disabilities of arm, shoulder & hand, plus the Beck

anxiety scale. Unable to discuss these indices and apparent lack of progress with the provider. The ODG would not support any additional sessions without documentation of a positive outcome with previous psychotherapy. “Thoroughly reviewed provided records including peer reviews. Given multiple mood and psychological issues, psychotherapy may be indicated for patients. However, it is unclear if patients making progress from past 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 provided records including peer reviews. Given multiple mood and psychological issues, psychotherapy may be indicated for patient. However, unclear if patient making progress from past X. 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)