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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)

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 is a X who was injured on X. X stated that X. The diagnoses were multiple closed fractures of bilateral ribs, sprain of ligaments of the cervical spine; strain of muscle, fascia, and tendon at the neck level; radiculopathy of the cervical region, sprain of ligaments of the thoracic spine, strain of muscle and tendon of the back wall of the thorax, and sprain of ligaments of the lumbar spine. Per a Report of Functional Capacity Evaluation dated X completed by X, DC, stated that X was seen for a Functional Capacity Evaluation (using the Blankenship protocol) to reassess X ability to return to work and / or the need for X. X had the history of work-related injury dated X. X stated that X. The ongoing complaints included intermittent bilateral rib pain with a reported intensity of X, frequent pain in the low back with a reported intensity of X. X also reported continued numbness and tingling into the right lower extremity; constant pain in the neck with a reported intensity of X. X also reported continued numbness and tingling into both upper extremities. Physical examination revealed X was well developed, well-nourished. X was oriented to time, place and person. Radial, ulnar, posterior tibial and dorsal pedis pulses were normal bilaterally. Gait evaluation revealed X. Cervical spine and paraspinal musculature revealed X. Torso / ribs examination revealed X. Lumber spine and paraspinal musculature examination revealed X. Cervical spine examination showed X.

Shoulder depression was X. Jackson's Compression was X. Lumber spine examination showed X. The slump test was X. Kemp's test was X. Straight leg raise (SLR) was X. Double leg raise could not be performed bilaterally due to pain. Hibb's test was X. Neurological examination revealed X. The sensory exam showed X. Motor examination revealed a grade X strength rating involving cervical extension; thoracic spine bilateral rotation due to rib cage pain; lumbar: extension; upper extremities was graded X; lower extremities was graded X. The active range of motion of lumbar spine showed flexion was X degrees, extension X degrees, right lateral rotation X degrees and left lateral rotation X degrees. Cervical spine showed flexion was X degrees, extension X degrees, right lateral rotation X degrees, left lateral rotation X degrees, right rotation X degrees, and left rotation X degrees. Thoracic spine examination showed flexion was X degrees, extension X degrees, right lateral rotation X degrees and left lateral rotation X degrees. The results of the evaluation included as X occupation's job demand was medium physical demand level and at the time, X was performing as sedentary to light physical demand level as per NIOSH Standards. X was capable of performing at a Sedentary to Light physical demand level involving the injured area(s) and continued to experience a severe functional deficit as it related to meeting the bending (currently infrequent vs frequent job requirement), reaching overhead (currently occasional vs frequent job requirement), reaching out (currently occasional vs frequent job requirement), climbing (currently infrequent vs occasional job requirement), squatting (currently occasional vs frequent job requirement),

floor lifting (currently X pounds vs X pounds job requirement), floor to shoulder Lifting (currently X pounds vs X pounds job requirement), floor to overhead lifting (currently X pounds vs X pounds job requirement), two hand carrying (currently X pounds vs X pounds job requirement), pushing (currently X pounds vs X pounds force required job requirement) and pulling (currently X pounds vs X pounds force required job requirement) job criteria as defined by the Dictionary of Occupational Titles and/or X Job Description Interview. The recommendations included that X had X. X demonstrated the following functional regressions: bending (from occasional to infrequent), floor lifting (from X pounds to X pounds), floor to shoulder lifting (from X pounds to X pounds). X X mental health evaluation revealed a BDI of 21/63 (18/63 on X, 22/63 on X) indicating moderate depression, BAI of 25/63 (17/63 on X, 20/63 on X) indicating moderate anxiety, FABQPA of 24/24 (20/24 on X, 22/24 on X) and a FABQWP of 42/42 (36/42 on X, 24/42 on X) indicating increased maladaptive fear avoidance behavior with physical activity and work activity. While X had demonstrated an increase in X physical and functional abilities during the X, X struggled to improve during the X mainly due to increased pain as X limiting factor when X workload was increased. This was supported by the following: increased muscle guarding of the lumber spine, increased hypertonicity and myalgia with palpation, decreased ranges of motion due to pain, increased VAS with sitting and standing and material handling as well as increased RPE. Additionally, the increased pain resulted in increased psychophysical and psychosocial pain behavioral patterns as X struggled with the mental barriers involved with X

ability to return to work as well as the financial issues, family and social issues related to X work-related injury, again, toward the latter stages of X work hardening program when the volume of X workload was increased. Based on the results of this exam and considering the X mental health evaluation, the recommendation of the mental health evaluation (MHE) that an X would be appropriate for X as X met at least X of the X criteria for multidisciplinary pain management programs as defined by the ODG and other methods of treating chronic pain had been unsuccessful and there were no other options for X that were anticipated to result in clinical improvement. The X would allow time to address X continued moderate depression and increased anxiety while continuing to build on X functional / physical gains. Additionally, regarding X motivation to return to work and significant progress X had made functionally, participation in this program was anticipated to result in further material recovery, return to work and maximum medical improvement. On X, X was seen by X, LPC for evaluation. X stated that X made some good objective progress from the X. In X they addressed situational depression, anxiety, and developing and strengthening coping skills. X was experiencing borderline clinical depression at the time; however, treatment in the X was recommended. X depressive symptoms and emotional distress were related to X work-related incident, and the possibility of the incident occurring again. These issues came up repeatedly in sessions. X progress was evidenced by the scores on both the Beck Depression Inventory-II, Beck Anxiety Inventory-II, and the Importance and Confidence Scale. X previous score on the BDI

was 21/63 indicating moderate depression and X ongoing score decreased to 18/63, indicating borderline clinical depression. X previous score on the BAI was 25/63 indicating moderate anxiety and X ongoing score decreased to 20/63 moving to median level of moderate anxiety. X previous score on the Importance and Confidence Scale was 10/10 very important to reduce and manage X anxiety more effectively and 10/10 important to return to work, 10/10 in being very confident in learning new ways to reduce and manage X depression and anxiety and 10/10 in having high confidence in returning to work at the time. X ongoing scores for the Importance and Confidence Scale were 10/10 on being very important to reduce X depression and anxiety more effectively; 5/10 somewhat important for X to return to work; 10/10 on very confident in learning new ways of reducing X depression and anxiety and 10/10 high confidence in returning to work, at the time. X benefited from individual therapy sessions and was open and ready to continue X treatment in the X to complete X goals and continue to improve X symptoms, practice skills and techniques. Being in a group setting with others would help to build X confidence to return to work and manage interactions with others. This would highly benefit in strengthening X coping strategies and provide an opportunity for the counselor to assist in providing feedback to X as X interacted with others. Recommendations included X had X. The following goals had been set: *Decreased X BDI levels by 3-4 points moving to Mild Mood Disturbance. Decrease X BAI levels by 3-4 points moving to Mild Anxiety. Improve confidence in self to return to work with healthy and effective coping skills to manage any

residual depression or anxiety symptoms. Counseling sessions within the Behavioral Chronic Pain Management Program would include patient education, problem solving, cognitive restructuring, and supportive treatment. Strongly recommend X attend X. An MRI of lumbar spine dated X showed central / left subarticular / left foraminal disc herniation was demonstrated. The disc herniation measured 6 mm within the left foraminal region. The disc herniation produced severe left neural foraminal stenosis and contacted the exiting left L2 nerve. Mild left lateral recess stenosis was also noted. Circumferential disc bulge measuring 3 mm was demonstrated, Hypertrophic facet arthropathy and ligamentum flavum hypertrophy contributed to severe central and bilateral lateral recess stenosis. Anterolisthesis at X was noted with L4 anterior with respect to L5 measuring X. An MRI of cervical spine dated X showed at C3-C4 level, there was posterior central X disc protrusion (herniation) indented the central cord with mild canal stenosis and moderate bilateral neural foraminal stenosis. At C5-C6 level, there was posterior central / bilateral foraminal X disc protrusion (herniation) intended the cervical cord with mild canal stenosis and severe bilateral neural foraminal stenosis. At C6-C7 level, there was posterior central X disc protrusion (herniation) indented the cervical cord with mild to moderate left neural foraminal stenosis. Canal was patent. There was multilevel foraminal stenosis with severe contact on bilateral C6 nerve roots and moderate contact on bilateral C4 nerve roots in the foraminal spaces. An MRI of thoracic spine dated X showed at X. At X. Neural foramina were patent. At X, there was X. Neural foramina

and canal were patent. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per the submitted documentation, the request is not warranted. A prior affiliated X was non-certified on X under X since the claimant has shown partial improvement with previous treatments including X; thus, the request does not meet the criteria for an X. The cited guideline supports X. In this case, the claimant presented complaints of borderline clinical depression, intermittent bilateral rib pain, frequent pain in the lower back, and constant neck pain associated with numbness and tingling into the right lower extremity and bilateral upper extremities. There were clinical findings of borderline clinical depression, median level of moderate anxiety, guarding of the lumbar spine, pain during palpation, hypertonicity with myalgia, bilateral cervical facet loading pain, paraspinal and upper trapezius hypertonicity, positive provocative tests, decreased deep tendon reflexes, residual muscle weakness, and decreased range of motion. They were noted to have a medium physical demand level and currently performed at a sedentary-to-light physical level. They continued to experience several functional deficits related to bending, reaching overhead, reaching out, climbing, squatting, floor lifting, floor-to-shoulder lifting, floor-to-overhead lifting, two hand carry, pushing, and pulling. They had an FABQPA score of 24/24 (20/24 on X, 22/24 on X) and an FABQWS sore of 42/42 (36/42 on X, 24/42 on X), which indicated increased maladaptive fear avoidance behavior with physical activity and work activity. Prior treatments included X. The physical elements or goals of

the requested program were noted as: muscular and connective tissue flexibility, muscular endurance and strength, cardiovascular conditioning, body mechanics training, real work simulation activities, vocational counseling and intervention in the form of group sessions, and individual sessions to address injury-related depression, anxiety, and coping strategies, desensitize pain, desensitize fear of work-related activities, and motive the claimant on being less focused on pain to return to work. Additionally these goals were set during the requested program: decrease their BDI levels by X points moving to mild mood disturbance; decrease their BAl by X points moving to mild anxiety; improve confidence in self to return to work with healthy and effective coping skills to manage any residual depression and anxiety symptoms; and counseling sessions within the behavioral chronic pain management program would include education, problem solving, cognitive restructuring, and supportive treatment. Although there were chronic complaints of pain and functional deficits along with their overall clinical findings and specific programs focused to improve on both psychological and physical aspects, their symptoms were mostly related to fear avoidance as evidenced by a guarding behavior, depressive symptoms, and emotional distress due to the possibility of the incident to reoccur. Moreover, although there were functional regressions following X, there were some improvements in both physical and psychological symptoms documented following other forms of conservative management. As such, the request failed to satisfy the guideline criteria that would warrant the medical necessity for an extensive

multidisciplinary rehabilitation program at this time. Furthermore, there were no extenuating circumstances noted that would warrant a deviation from the guideline recommendations. Therefore, the prospective request for X is non-certified. “On X, Dr. X wrote an appeal letter regarding denial of X. It was stated that “First, there was no request for X in the submission, so I am not sure why this is mentioned in the review. Second. While the claimant demonstrated overall increases in X physical and functional abilities as well as decreases in X depression and anxiety during the X, I agree with the peer review that fear avoidance behavior was the main factor for the regression during the X which resulted in no significant progression in X physical and functional abilities and increases in X depression and anxiety. These issues were addressed during individual therapy sessions after the X and this resulted in improvements in X depression and anxiety per the X mental health report (erroneously dated X). The exceptional factor in this case remains fear- and despite learning coping skills to avoidance behavior address this in the X and in X, further coping strategies are needed. Additionally, the increased X in the X will further address the fear-avoidance behavior and the concurrent physical activity in the X can further reinforce the coping strategies as X performs the activities that trigger the behavior. Therefore, the X in this case is medically necessary. Additionally, the claimant meets at least X as defined by the ODG and other methods of X have been unsuccessful and there are no other options for the claimant that are anticipated to result in clinical improvement. Therefore, we are requesting an appeal and approval for an X.”

Per a reconsideration / utilization review adverse determination letter dated X by X, DC, the request for X was denied. Rationale: “Concerning this appeal, it appears that providing the claimant with the requested treatment is not warranted. The provider, X, DC, submitted an appeal on X with no new clinical findings. Per appeal letter, the provider stated that the claimant demonstrated overall increases in their physical and functional abilities as well as decreases in their depression and anxiety during the X, I agree with the peer review that fear avoidance behavior was the main factor for the regression during the X which resulted in no significant progression in their physical and functional abilities and increases in their depression and anxiety. These issues were addressed during individual therapy sessions after the work hardening program and this resulted in improvements in their depression and anxiety per the X mental health report (erroneously dated X). The exceptional factor in this case remains fear-avoidance behavior and despite learning coping skills to address this in the X and in X, further coping strategies are needed. Additionally, the increased X in the X will further address the fear-avoidance behavior and the concurrent physical activity in the X program can further reinforce the coping strategies as the claimant performs the activities that trigger the behavior. Therefore, the X in this case was medically necessary. Additionally, the claimant meets at least X of the X criteria for X programs as defined by the ODG and other methods of treating chronic pain have been unsuccessful and there are no other options for the claimant that are anticipated to result in clinical improvement. In this case, I concur with the prior determination

of noncertification. The claimant underwent various treatment/programs due to their chronic pain which responded to previous treatment. However, the claimant experienced a functional regression following the X. It was noted that fear avoidance is the main reason of the said functional regression wherein per the providers appeal letter were already addressed during X after the X. In addition, the provider stated that despite learning coping skills to address this in the X and in X, further coping strategies are needed. The claimant was noted to have developed and strengthened their coping skills following the X, thus it is not clearly rationalized as to what other/ further coping strategies is needed for the claimant's current condition that could be addressed by the requested extensive program. Given the conflicting information/evidence noted in this review, the request cannot be authorized and is not medically necessary at this time. Therefore, the request for X is non-certified.
"Thoroughly reviewed provided records including provider peer reviews. While patient has exhibited fear avoidance behaviors that are being addressed, this is not a valid reason to excuse the individual from participating in the described X program. The patient meets the criteria cited by peer reviews and the provider has valid reasoning to continue program. Given objective measures the patient is working towards, request is necessary. Recommend prospective request for 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 peer reviews. While patients have exhibited fear avoidance behaviors that are being addressed, this is not a valid reason to excuse the individual from participating in the described X program. The patient meets the criteria cited by peer reviews and the provider has valid reasoning to continue program. Given objective measures the patient is working towards, request is necessary. Recommend prospective request for 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)**