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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: 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: PM&R/Pain Medicine

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-year-old X who was injured on X. X was injured while X. The diagnoses were crush injury of the left wrist, dislocation of the left wrist and hand, fracture of the mid-navicular bone of the left wrist, and left carpal tunnel syndrome.

Per a Mental Health Evaluation dated X completed by X, LPC / X, LPC, X presented for mental health evaluation of X ongoing complaints. X was referred for a Mental Health Evaluation due to the following indications: significant impairment in daily functioning and failure to return to work. X injury occurred on X while working as a X where X had been for X years. X was injured while X. X had not worked since X injury. On psychiatric examination, X was appropriate and well groomed. Behavior showed X. Speech was X. Affect was X. X reported problems with X. There was no X. No evidence of X. Assessment instruments were as follows: Structured Clinical Interview Pain Intensity Scale, Pain Disability Questionnaire (PDQ) Insomnia Severity Index (ISI), Central Sensitization Inventory (CSI), Fear-Avoidance Components Scale (FACS), Generalized Anxiety Disorder - X (GAD-X), Patient Health Questionnaire - X (PHQ-X) and Quick Inventory of Depressive Symptomatology (QIDS). Test Results were as follows: Insomnia Severity Index (ISI) was X (moderate sleep disturbance), Fear-Avoidance Components Scale (FACS) was X (moderate fear-avoidance symptoms), Pain Intensity Scale (Pain) was X (severe pain intensity), Central Sensitization Inventory (CSI) score was X (subclinical central sensitization symptoms), Pain Disability Questionnaire (PDQ) score was X (severe disability), Generalized Anxiety Disorder (GADX) score was X (minimal anxiety), Patient Health Questionnaire - X (PHQX) score was X (minimal depressive symptoms), Quick Inventory of Depressive Symptomatology (QIDS) score was X (severe depression). It was opined that, X may have under-reported X level of symptomology on the X. X reported no ongoing use of X. The following critical barriers were identified that were preventing pre-morbid level of psychosocial function: for psychological functioning, the development of depressive symptoms, development of anxiety symptoms, significant level of pain sensitivity and / or fear of re-injury, loss of self-esteem, sleep disturbance, diminished interest and pleasure in daily activities and racing thoughts; social

functioning included social isolation, disruption in the quality of important interpersonal relationships with others, inability to fulfill normal family and social obligations (i.e., emotional and / or financial support of other family members); for physical / behavioral functioning, disability with activities of daily living and inability to work and for additional barriers to full psychosocial functioning, enduring pain, language and / or cultural barriers and appetite disturbance. The assessment was adjustment disorder with mixed anxiety and depressed mood. In summary, based on the results of this evaluation, it was determined that X would likely benefit from a X. The X used a X. This was an X, which meant that an integrated treatment team of highly trained and experienced professionals were on site, full time, available to X on a daily basis, and dedicated entirely to patient care. The goal of the X was to help patients with disabilities to increase psychosocial and physical functioning to as high a level as possible, and to manage pain as effectively as possible, so that they could resume a productive lifestyle. A quantitative functional capacity evaluation (FCE) was completed by X, OTR, on X. The purpose of X was quantification of safe functional abilities and guidance for intervention and treatment. X presented for evaluation of chief complaint of "Pain in the wrist and left arm all the time." Mechanism of injury noted that X. The machine pulled X left arm into it causing an injury to X left shoulder, left elbow, and left hand. Regarding work status, X was not working but still employed. Pain level, at pre-test was X, minimum level of pain reported during testing was X, maximum level of pain reported during testing was X, and post-test was X. It was concluded that as the X results were considered self-limited with some tests due to observed inhibition, X did not meet lifting requirement for the job. X did not meet carrying requirement for job. It was critical that X had improved active range of motion (AROM) and strength for maximum job performance. Isolated tests for range of motion (ROM) and/or strength identified deficits which would make it difficult or unsafe to perform carrying, lifting, pushing, or pulling. X with emphasis on strengthening and conditioning to address musculoskeletal deficits, learn pain negotiating techniques and train in progressive return to work activities, was recommended. At the time, X was performing at a Below Sedentary PDL. On X, X was seen by X, DO, for follow-up evaluation of postoperative left wrist and forearm pain. The pain radiated down to the hand and up to the shoulder (with the carrier accepting "dislocation of the left wrist and hand, displaced fracture of the mid left navicular bone, left carpal tunnel syndrome, and left wrist crushing injury"). The pain originated since the

injury dated X. It was continuous and frequently severe, and modified by increase in activity level. X had appropriate diagnostic testing and therapeutic procedures up to the ongoing time. X had increased pain with any activity and numbness radiating up to the elbow. On examination, mood and affect were somewhat flat. The left wrist examination was essentially unchanged, with significant weakness with resisted motion, range of motion deficits, and significant weakness with grip strength noted. Dr. X assessed that again there had been a double denial for the X. X was considering requesting an IRO to see if anything could be done to try and get X this medically necessary and important treatment. Otherwise, X was still not working and honestly could probably be back at work at the time if they had gotten approval for X to participate in the program. Dr. X also stated that X had an X. This was not a fusion of every bone in the wrist; therefore, there was significant room for improved function and range of motion of the wrist in general. Additionally, X would, within significant medical certainty and reasonableness, improve the grip strength and improve strength overall in the wrist and hand, thus improving X function and allowing X to return to gainful employment. Dr. X would reach out to the adjuster, to see if there was any possibility to override this obviously flawed denial, as it completely negated any possibility for anyone who had been injured to recover in any way.

Treatment to date included X.

Per a utilization review adverse determination letter / peer review dated X, the request for X was denied by X, MD. Rationale: “The Official Disability Guidelines require that previous methods of treating chronic pain have been unsuccessful and that no other options are likely to result in significant clinical improvement before approving an X. The ODG guideline criteria have not been met. The ODG guidelines support X under specific criteria, but in this case, the patient has not met those criteria. The patient, evaluated on X for chronic disabling pain rated X, has not received adequate lower-level care such as X. Despite X ongoing pain and functional deficits after a crush injury to X left wrist and forearm on X, X has only had X. On X, a peer review certified the request for X. However, the submitted medical records do not show completion of the X. Furthermore, psychological screening scores included a Fear-Avoidance (FACS) score of X, indicating moderate levels, a Pain Disability Questionnaire (PDQ) score of X, classified as severe, an Insomnia Severity Index (X) score of X, classified as moderate, a PHQ-X

depression score of X, classified as minimal, and a GAD-X anxiety score of X, also classified as minimal. The patient's functional capacity evaluation shows X is at a sedentary level, whereas X pre-injury job required medium to heavy lifting capabilities. Job demands are not met include gripping, fingering, and handling. Moreover, it remains relevant that the necessary rehabilitation steps to justify an X have not been met. It is not very likely that X will meet the functional requirements of X previous occupation through an X without first trying standard first and second-line conservative treatment. Therefore, my recommendation is to NON-CERTIFY the request for X."

On X, Dr. X wrote an appeal / reconsideration letter after an initial denial of the X. The denial reason from the Peer Doctor (PMR specialty) was as follows: "The records do not show that the patient has had X." In response to the concerns of the X preauth doctor, Dr. X documented, "First, I would like to take a moment to point out that this denial determination was made without the completion of peer-to-peer discussion, as should be afforded per DWC guidelines. I also would like to point out that multiple phone contact attempts and/or messages were made/left for the peer reviewer assigned to this review prior to the due date and time with no call back from the peer receiver prior to the rendering of this denial. This is a violation of the guidelines. Now as for the peer reviewer's only "reason" for denial, either the peer reviewer did not review the documentation submitted in support of this request OR all of the documentation was not forwarded to the peer reviewer for review. IF the peer reviewer had reviewed the submitted documentation, or if it was forwarded to X, X would have seen that completion of adequate X. However, I will take a moment to re-outline those lower levels of care. X underwent a X. Post-operatively the patient has completed X. As for X, the patient is not a candidate for X, as X has continued elevated levels of fear-avoidance and pain/perceived disability even after the cognitive behavioral therapy sessions. X is basically a unimodal form of care and would only address the physical deficits the patient continues to demonstrate. Furthermore, a X would not address the continued use of prescription medications (X). In summary, X has completed X. X has, objectively, clear, significant deficits with respect to X work demands, testing at a Below Sedentary Physical Demand Level (PDL); required to reach a Medium-Heavy PDL. There are some mental health restrictions and components, mainly regarding fear-avoidance and perceived disability. From looking at these parameters, this patient is an excellent candidate

for participation in the X. From a discussion with X, X has clear motivation to engage in this program and continue to try to achieve return to full capacity employment. Patient continues to demonstrate chronic pain behaviors with continued limitation in function, lower levels of care have failed to restore pre-injury function with insufficient physical capacity to pursue work and/or family needs, demonstrates development of psychosocial sequelae, continues to have inadequate pain control & exhibits reliance on medications and demonstrates withdrawal from social activities. The patient does express motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). Additionally, the patient is aware that successful treatment may change compensation and/or other secondary gains. Based upon the evaluations and additional factors including inhibition of physical function, terminated from job, heavy job demands, job demands require repetitive motion and/or static positioning, limited education/skills, extended period of disability, and financial stressors, it is felt the patient would benefit from a X. X prognosis is good and X goals of treatment are (see below). We anticipate X can reach these goals with X. The Treatment Plan for this patient involves X. A X. It will result in X similar to what is used in national sports centers for professional athletes. The psychosocial comorbidities will be dealt with through a X. Goals for this patient include: a) improve functional materials performance; b) improve handling capability from current level to Medium-Heavy; c) increase work intensity and/or duration from off work to full duty; return to work full duty; d) prevent recurrent injury by increasing functional capacity and endurance; e) achieve Maximum Medical Improvement (MMI); f) improve pain and stress management skills; and g) learn cognitive behavioral methods to overcome psychosocial barriers to treatment participation and return for work. Once authorized, this patient will begin in the X. The first X are requested (per the guidelines) to allow Concurrent Review to determine attendance, compliance and progress. If program continuation is warranted at that time, an individualized treatment plan (duration, visits and hours) will be submitted. This patient will return for reassessment in X weeks. In the course of this evaluation, the potential risks and benefits of a progressive exercise program were discussed with the patient. These risks include, but are not limited to, increased muscle tightness, joint irritation, overuse and pain. It was emphasized that reactivation of muscles, connective tissue and joints following a period of inactivity and/ or postoperative recovery may be associated with an exacerbation of some symptoms, which

generally does not constitute an injury. The sports medicine approach to regaining function and decreasing pain through treatment was reviewed and the patient's questions and concerns were addressed. These recommendations reflect my medical opinion on cost-effective treatment designed to achieve mutually desired goals of return to work, case closure, decreased health utilization, lower risk of recurrent injury and/or functional status as close to preinjury levels as possible. At the conclusion of the treatment process a Long-Term Care Plan (LTCP) will be developed to deal with ongoing disability, medication, work adjustment and other health utilization issues."

Per a reconsideration review adverse determination letter / peer review dated X, the request for X was denied by X, MD. Rationale: "ODG states: X may be recommended when there is an appropriate pain condition for rehabilitation. A prior request for a X for the left wrist and hand was noncertified on X. The provider has submitted a reconsideration letter stating "the patient has completed X." I spoke with X. X stated that the claimant had X. No other significant information was exchanged during the conversation. At this juncture, the claimant is deemed to be at below sedentary PDL. X is able to pull/push/lift between 0-X Ib up to the shoulder line and nothing above the shoulder line. X current job description requires X to be at medium to heavy PDL with the ability to pull/push/lift up to X Ibs. The claimant had extensive anatomical injury to the left wrist resulting in multiple fractures/dislocation/soft tissue injury and disruption. After X the claimant remained with significant physical/anatomical deficits. With a reasonable degree of medical certainty none of these deficits can be cured/reversed/restored through any form of counselling/advice/manipulation/therapy. Given the physical limitations of this claimant, the request is not medically reasonable. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL: X.

Thoroughly reviewed provided records including provider notes and peer reviews.

The patient continues to have complex pain issues resulting in functional deficits that have been extensively documented. The patient has X. The request meets the cited guidelines and is medically necessary. 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.

The patient continues to have complex pain issues resulting in functional deficits that have been extensively documented. The patient has X. The request meets the cited guidelines and is medically necessary. 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)**