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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 who was injured at work on X. X worked as a X. On the date of injury, X stated, "I walked X. I started to feel pain in my right shoulder." The diagnoses were chronic right shoulder, arm, and hand pain, cannot rule out complex regional pain syndrome (neuropathic pain) following work injury; chronic neck pain associated with chronic right shoulder, arm and hand pain cannot rule out complex regional pain syndrome (neuropathic pain) following work injury, cannot rule out intervertebral disc disorder with radiculitis contributing to persistent shoulder and arm, hand pain complaints; reactive depression, moderate with insomnia associated with chronic pain state. X underwent an initial pain evaluation on X, by X, DO. X had severe neck pain radiating into X right shoulder, arm, and hand associated with swelling, sensitivity, burning sensations, involuntary spasms, all following a work injury on X. Due to X persistent neck, shoulder, and arm pain, X was evaluated for right shoulder injury, which on X, as evaluated by Dr. X was remarkable for X. X was not noted. X was noted. Unfortunately, X neck pain had not been evaluated and an MRI of the cervical spine was planned. X neck pain was worse with coughing, sneezing, sudden movements to the neck to the right. X considered X pain was X aggravated with most routine daily activities including coughing, sneezing, and lifting. X showed moderate reactive depression, poor sleep associated with this injury as X answered X. X GAD-X was X. X had tried X. Exam noted X did walk with an antalgic limp and gait. Neck revealed X. X were noted in the cervical, interscapular, and rhomboid regions. X had decreased grip strength on the right and X hand was swollen on the right. A better than X-degree Fahrenheit difference in temperature was noted across the dorsum and palmar aspect of the right hand, which was cold to touch as compared to the left hand and there was a dusky bluish tint on the right as compared to the left. X had pain with passive range of motion throughout the right shoulder, elbow, and wrist. X had pain with light touch as well as passive range of motion. X were noted in the neck, cervical and upper back area. X had X. X had limited range of motion to the right shoulder, approximately X of normal. The diagnoses were chronic right shoulder, arm, and hand pain, cannot rule out complex regional pain syndrome (neuropathic pain) following work injury; chronic

neck pain associated with chronic right shoulder, arm and hand pain cannot rule out complex regional pain syndrome (neuropathic pain) following work injury, cannot rule out intervertebral disc disorder with radiculitis contributing to persistent shoulder and arm, hand pain complaints; reactive depression, moderate with insomnia associated with chronic pain state. Dr. X noted X prognosis was fair. Initial medical management would include X. X was added to X ongoing medication regimen as well as X. An X, improved sleep was encouraged. Active range of motion exercise throughout X upper extremities bilaterally was encouraged. On X, X was evaluated by Dr. X. Dr. X noted X was already noticing some improvement of X hand pain complaints. X was still having sensitivity to touch, swelling, coldness about X arm and hand, hyperesthesia with passive range of motion and allodynia which was elicited that day consistent with complex regional pain syndrome of the right shoulder, arm and hand associated with a work injury. As a result, Dr. X recommended X. They went over X recent MRI of the cervical spine. There was no obvious pain generator. Therefore, based on their clinical finding, this was a diagnosis of exclusion as well as repetitive evaluations. X symptoms were consistent with X. As a result, Dr. X recommended X. X was to continue with X, which X stated was already helping. That supported the diagnosis. This was a neuropathic pain process as X was responding to neuropathic pain treatment. X was sleeping better with X. X as well. XPMP was satisfactory. X SOAPP showed moderate reactive depression, which was improving with the ongoing drug regimen, and X would be scheduled for this pending insurance authorization. Per the X note, Dr. X noted X continued with moderate-to-severe swelling, shoulder pain, pain with passive range of motion, hyperesthesia, and allodynia. Infrared thermometry revealed more than a X degree difference in the right shoulder and upper brachium extending into the hand as compared to the unaffected limb. Unfortunately, X received a peer review counter to prudent reasonable necessary treatment both under the ODG guidelines as well as the Texas Labor Code, which specifically stated patients were due treatment that ameliorated or relieved the natural compensable disease state. Delays in the treatment of X only led to further spread, further deterioration, suffering as well as disability, which could be anticipated. It was not in the interest of X certainly nor the insurer to see that X did not receive reasonable necessary treatment, which was the X as practiced by Dr. X. Unfortunately, the peer process had done a disservice to X as well as the

healthcare system at large. As a result, Dr. X had to bring X back in and had to review why this was denied. Dr. X documented, “I reviewed the copy and paste, that is right a copy and paste review without even a physician's name attached as to why this was denied. We can only surmise that the doctor who reviewed this case is neither educated, trained or experienced in the treatment of this disorder. This patient has exhausted all X. Apparently, the doctor did not do their due diligence to determine that. Furthermore, the harden criteria has already been met as outlined on my initial evaluation and the previous physician who referred this patient for X. There are no other disorders that constituted this amalgam of symptomatology both objectively and subjectively. This delay unfortunately has led to further pain as the patient continues to states, X is having difficulty with activities now of daily living. X has anisocoria, that is right doctor look that one up, that means central sensitization and glial cell activation has occurred· As a result of this denial, we are going to resubmit immediately for a X which will provide further diagnostic and therapeutic benefit.” Based on response to that care and the anticipated Horner syndrome which would accompany a technically successful block, further X. Spinal cord stimulation would be reserved for recalcitrant pain. Already, X stated the medicines that Dr. X had started X on specific for this disorder had worked. X was sleeping for the first time. X was no longer getting the dystonic spasms, which often accompanied this disorder. X affect had improved as had X which Dr. X had raised the dose of, and X. X with Dr. X were advised. An MRI of the cervical spine dated X, demonstrated straightening of the expected degree of cervical lordotic curvature, most likely due to muscular spasm, strain, and / or pain. X were present throughout the cervical spine. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “In this case, there is no record of physical examination findings that would satisfy the X. There is no record of plans for a X. It is also not explained X. The request is not shown to be medically necessary. Therefore, the request for X is non-certified.” Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “In this case, based on the information provided, the patient has rt shoulder, neck, and arm pain. X. The plan is X. According to the Official Disability Guidelines (ODG), X are “not recommended as a X.” Given the lack of strong supporting evidence and current clinical guidelines, the request for a X is not considered medically necessary at this time. Therefore, the appeal request for

X is upheld and non-certified.” Thoroughly reviewed provider notes including peer reviews. The patient meets diagnostic criteria for CRPS and the provider is pursuing a diagnostic X. While there is X. If the provider X. On the other hand, X is commonly utilized for this procedure given X. Thus, request for X is medically necessary, regardless of X. 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 provider notes including peer reviews. The patient meets diagnostic criteria for X. While there is X. If the provider X. On the other hand, X is commonly utilized for this procedure given X. Thus, request for X is medically necessary, regardless of X. 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)**