

Independent Resolutions Inc.

An Independent Review Organization

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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:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X sustained an injury while X. The diagnoses were chronic right wrist and arm pain associated with swelling, hyperesthesia, and allodynia following a traumatic work injury, consistent with complex regional pain syndrome (CRPS) stage I-II.

On X, X was seen by X, DO, for initial evaluation for X right hand / wrist pain. X presented for evaluation of chronic persistent right wrist pain associated with swelling, sensitivity, and burning temperature and color changes; all following a work injury on X. X reported, at work, X was lifting some heavy packages and throwing it onto the belt. X felt X right arm pop, and X dropped the bag. Swelling, sensitivity, and severe pain was noted. X was ultimately worked up for this injury and was determined to have ligamentous damage with previous osseous fusion at the distal interphalangeal (DIP) and proximal interphalangeal joint (PIP) joints. Benign ganglion cyst or lymph node was also noted. Suspected triangular fibrocartilage tear however, was also noted. X ultimately underwent surgery for functional improvement. Unfortunately, X pain had persisted at a moderate-to-severe grade. X graded X pain at 6 to 9/10 that day. It was affecting X daily quality of life, sleeping. X often felt it was throbbing at night, and it was in a semi-cast brace device. X was also noting stiffness about X elbow and dystonic spasms up into X neck and shoulder. X admitted to sleep loss, and mood irritability. A pain related stress inventory was remarkable for 13/60 on X CESD. X risk for opioid misuse was zero. X GAD-7 was 20/21. PMP was satisfactory consistent with chronic neuropathic pain, as X was incidentally also being treated for X right shoulder. Physical examination revealed X was in moderate to severe distress to chief complaint. Neck was supple with decreased right rotation to 40 degrees, left rotation to 60 degrees. The musculoskeletal examination showed marked hyperesthesia, and sensitivity to touch above X cast was noted. X fingers were also swollen with infrared thermometry temperature checks more than 2-degree Fahrenheit coldness as compared to the left unaffected limb. Trigger points throughout the cervical, interscapular, and rhomboid regions were also noted. Treatment plan was X. On X, X was seen by X, for follow-up visit for X right hand / wrist pain. X assessed that X was taking treatment for X right wrist, arm and hand pain associated with X date of injury X. At the time, X hand was mildly hyperesthetic. X did have evidence of complex regional pain syndrome (CRPS). Sympathetic blockade was recommended. X discussed X which would help X with the swelling and edema. X was going to arrange for pending insurance authorization. Further delays in this treatment would lead to refractory and costly pain complaint. X also stated that, in addition, apparently, a peer review physician neither educated, trained in interventional pain care and without certification in the specialty X had opined, had limited knowledge and had declined reasonable necessary treatment under the ODG guidelines, which included sympathetic blockade for reflex sympathetic dystrophy currently known as complex regional pain syndrome. Evidenced based medicine as well as the Texas Labor Code stated the patients were due treatment that ameliorated or relieved the natural compensable disease state. X's over 30 years of treatment with over thousands of X had often offered sustained and ameliorative relief for this disorder. Higher levels of care X would only be offered should X when done in a repetitive and systematic manner with active range of motion exercises reached a plateau. Further delays in this treatment as a result of this denial, would only lead to refractory pain, disability, and increased healthcare cost. As a result, immediate approval was recommended for X performed by X safely and effectively as thousands of patients had already received this care with good result, oftentimes X could completely ameliorate the patient's disorder. Furthermore, the peer doctor did not offer any alternative treatments in X denial of this treatment. X would resubmit the request for insurance authorization.

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An MRI of right hand dated X revealed large central fibrocartilage tear with associated fluid in the distal radioulnar joint. Extensor carpi ulnaris tendinosis was noted. Mild triscaphe and thumb carpometacarpal joint (CMC) joint degenerative joint disease (DJD) was noted.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome as defined by failure of symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic or ultrasound guidance. Per submitted documentation, the request is not warranted. A prior review on file for X was non-certified because the guidelines do not recommend it due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. The referenced guidelines recommend that X not be a first-line treatment for complex regional pain syndrome (CRPS) due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. According to the guideline, this procedure may only be considered after failure of conservative treatment, including a comprehensive functional restoration program and medication management. It should also be performed under fluoroscopic or ultrasound guidance when clinically indicated. Based on the injured worker's clinical findings of chronic right wrist and arm pain with hyperesthesia, allodynia, dystonia, and proximal spread of symptoms despite prior surgery, physical therapy, medication, and orthosis, the request is not supported by the guideline recommendation. Since the injured worker did not demonstrate failure of a comprehensive functional restoration program as defined in the guidelines, and the benefit of X remains unproven, the request is not medically necessary to treat the current condition. Therefore, the prospective X for the X is noncertified."

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as a X. After the review of the submitted documentation, it appears the prior non-certification was appropriate. The referenced guidelines state that X is not recommended as a first-line option due to evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program functional restoration program led by occupational or physical therapist for 3 months and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as a X. Although the injured worker had symptoms chronic regional pain syndrome in the upper extremity, the request is not recommended by the guidelines due to inconclusive benefit, lack of benefit, or potential harm and there was no indication of failure of other treatments such as functional restoration program led by occupational or physical therapist for 3 months in which the guidelines were not met. Therefore, the appeal request for X is non-certified."

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and

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redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome as defined by failure of symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic or ultrasound guidance. Per submitted documentation, the request is not warranted. A prior review on file for X was non-certified because the guidelines do not recommend it due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. The referenced guidelines recommend that X not be a first-line treatment for complex regional pain syndrome (CRPS) due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. According to the guideline, this procedure may only be considered after failure of conservative treatment, including a comprehensive functional restoration program and medication management. It should also be performed under fluoroscopic or ultrasound guidance when clinically indicated. Based on the injured worker's clinical findings of chronic right wrist and arm pain with hyperesthesia, allodynia, dystonia, and proximal spread of symptoms despite prior surgery, physical therapy, medication, and orthosis, the request is not supported by the guideline recommendation. Since the injured worker did not demonstrate failure of a comprehensive functional restoration program as defined in the guidelines, and the benefit of X remains unproven, the request is not medically necessary to treat the current condition. Therefore, the prospective request for X is noncertified." Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as X. After the review of the submitted documentation, it appears the prior non-certification was appropriate. The referenced guidelines state that X is not recommended as a first-line option due to evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program functional restoration program led by occupational or physical therapist for 3 months and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as a X. Although the injured worker had symptoms chronic regional pain syndrome in the upper extremity, the request is not recommended by the guidelines due to inconclusive benefit, lack of benefit, or potential harm and there was no indication of failure of other treatments such as functional restoration program led by occupational or physical therapist for 3 months in which the guidelines were not met. Therefore, the appeal request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of support for the requested X within the guidelines which note that evidence shows inconclusive benefit, lack of benefit or potential harm. There is no documentation of a functional restoration program. There are no exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial sympathetic block for complex regional pain syndrome as defined by failure of

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symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic or ultrasound guidance. Per submitted documentation, the request is not warranted. A prior review on file for X was non-certified because the guidelines do not recommend it due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. The referenced guidelines recommend that X not be a first-line treatment for complex regional pain syndrome (CRPS) due to inconclusive evidence of benefit, lack of proven effectiveness, or potential harm. According to the guideline, this procedure may only be considered after failure of conservative treatment, including a comprehensive functional restoration program and medication management. It should also be performed under fluoroscopic or ultrasound guidance when clinically indicated. Based on the injured worker's clinical findings of chronic right wrist and arm pain with hyperesthesia, allodynia, dystonia, and proximal spread of symptoms despite prior surgery, physical therapy, medication, and orthosis, the request is not supported by the guideline recommendation. Since the injured worker did not demonstrate failure of a comprehensive functional restoration program as defined in the guidelines, and the benefit of X remains unproven, the request is not medically necessary to treat the current condition. Therefore, the prospective request for X is noncertified." Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X, the Official Disability Guidelines does not discuss X within the hand/wrist chapter and redirects to relevant recommendations in the pain chapter and states that it is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial sympathetic block for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as a X with local anesthetic. After the review of the submitted documentation, it appears the prior non-certification was appropriate. The referenced guidelines state that X is not recommended as a first-line option due to evidence shows inconclusive benefit, lack of benefit, or potential harm. It may be indicated when the following criteria are met such as initial X for complex regional pain syndrome of upper extremity with failure of symptoms to improve after functional restoration program functional restoration program led by occupational or physical therapist for 3 months and failed medication treatment. Additionally, the procedure is performed under fluoroscopic guidance as a X. Although the injured worker had symptoms chronic regional pain syndrome in the upper extremity, the request is not recommended by the guidelines due to inconclusive benefit, lack of benefit, or potential harm and there was no indication of failure of other treatments such as functional restoration program led by occupational or physical therapist for 3 months in which the guidelines were not met. Therefore, the appeal request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of support for the requested X within the guidelines which note that evidence shows inconclusive benefit, lack of benefit or potential harm. There is no documentation of a functional restoration program. There are no exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified.

Upheld

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE