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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: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X. X was X. The diagnoses were nondisplaced fracture of body of scapula, left shoulder, initial encounter for closed fracture; unstable burst fracture of second lumbar vertebra, initial encounter for closed fracture; other fracture of first lumbar vertebra, initial encounter for closed fracture; other fracture of second lumbar vertebra; unspecified sprain of left shoulder joint, initial encounter; sprain of ligaments of cervical spine, initial encounter; and sprain of ligaments of thoracic spine, initial encounter.

Per a mental health re-evaluation report dated X completed by X, MS, LPC, the purpose of the re-evaluation was to determine whether X mental health factors were still inhibiting treatment benefit and ability to return to work in a complete capacity and to determine if X would benefit from a X. Regarding the history of present injury, X stated the event which precipitated this pain was when X was X. X stated X was initially unconscious, experiencing chest and neck pain, minimal movement on both sides. X continued to report high levels of pain. X had no history of psychological intervention for any reason. X had been treated with X. X expressed awareness of feelings of depression and frustration. X also expressed concerns about X inability to get good sleep as X had difficulty finding and maintaining a comfortable sleep position. X had been compliant with attendance and participation in X and saw the benefit of X. X exhibited symptoms of stress and anxiety during the course of the clinical interview. X affect was apprehensive, and X voice and demeanor reflected a high level of anxiety. Related to the injury, X complained of chronic pain, situational depression, anxiety related to X injury and concern over X vocational future, low energy due to lack of quality of sleep, financial stress, lack of coping skill, feeling lack of control and agitated state over concerns for future. Regarding Patient Health Questionnaire-X, X scored X, indicating moderate depressive symptoms, making it extremely difficult to take care of things at home, get along with others, or complete daily life tasks. X reported feeling down, depressed, or hopeless, trouble falling asleep or staying asleep or sleeping too much, feeling tired or having little energy, feeling bad about yourself - or that you are a failure or have let yourself or family down, trouble concentrating on things, such as reading the newspaper or watching television and having intrusive thoughts. Regarding Generalized Anxiety Disorder-X, scored X, indicating moderate anxiety symptoms, making it extremely difficult to take care of

things at home, get along with others, or complete daily life tasks. X reported feeling nervous, anxious, or on edge, not being able to stop or control worry, worrying too much about different things, trouble relaxing, being so restless that it's hard to sit still, becoming easily annoyed or irritable and feeling afraid as if something awful might happen. Regarding Fear-Avoidance Belief Questionnaire, X scored a high score (X) on the physical activity portion of the assessment and a high score (X) on the work portion of the assessment. Regarding Pain Impairment Rating Scale, X rated X pain as X at its worst, X at its least and X on average. Mental status examination revealed X appeared stated age, appropriately dressed and groomed. Psychomotor activity showed movements were somewhat stilted and stiff, activity level was reduced. Speech was normal, good volume and clear. X was cooperative and friendly. Mood was normal, affect was anxious and apprehensive. Regarding perceptual abnormalities, there was no apparent evidence of a perceptual disorder or hallucinations; X denied and none were evident. There was no evidence of a thought pattern that would suggest the presence of obsessive/compulsive traits, behaviors, delusions, phobias or symptoms. There was no evidence of thought disorder. Thoughts were organized, goal directed, and coherent. X was alert and oriented to person, place, and situation. Intellectual functioning was average. Memory and concentration was within normal limit. Insight showed good understanding of problems, fair coping skills. Judgment was good, able to understand facts. On assessment, X motivation was high; however, X was having difficulty adjusting to X present health situation. The following goals have been set: 1. Decrease X Depression level down X points moving X into mild depression symptoms. 2. Decrease X Anxiety level down X points moving X into mild anxiety. 3. Decrease X pain level X points in each level - worst, least, and average. 4. Counseling sessions will include patient education, stress management, problem solving skills, and cognitive behavioral therapy. X was strongly recommended to attend X. Per a Functional Capacity Evaluation report dated X completed by X, DC, X was evaluated for Functional Capacity Evaluation to reassess X ability to return to work and / or the need for additional rehabilitation. X stated that X complaints started since the injury that occurred at work on X. X stated that while X. At the time, X complained of constant pain in the low back with numbness and tingling into the right lower extremity. X reported the intensity of the pain to be X. X stated that bending, walking, standing, and activities associated with normal daily activities, would increase X overall pain level. X stated that medication and changing positions frequently had helped decrease X overall pain level. X also

reported a sharp pain on the anterior right side of the upper abdomen. X also complained of intermittent pain both shoulders, left more than right. X reported the intensity of the pain to be X in the right shoulder and X in the left shoulder. X stated that lifting the arms, reaching (out or above) and activities associated with normal daily activities, would increase X overall pain level. X stated that medication helped to decrease X overall pain level. The physical examination revealed X. There was X. Postural evaluation revealed X. X demonstrated difficulty getting up from a seated position. Lumbar spine and paraspinal musculature examination revealed X. Right shoulder and musculature examination revealed X. Left shoulder and musculature examination revealed X. Neurological examination revealed X: biceps X bilaterally, brachioradialis X bilaterally, triceps X bilaterally, patellar X on the left and X on the right, hamstring was absent bilaterally, Achilles was trace X on the left and X on the right. Sensory examination to light touch revealed X in the right X, X, and X. Motor examination revealed a grade X strength rating involving lumbar: flexion, extension; thoracic: right and left rotation; lower extremities: right great toe extension; upper extremities: bilateral shoulder elevation, bilateral shoulder abduction, and bilateral shoulder internal rotation. Lumbar spine examination revealed X. Slump Test was X. Kemp's Test was X. Double Leg Raise was X. Right shoulder examination revealed X. Hawkins-Kennedy test was X. Painful Arc test was X. Left shoulder examination revealed X. Hawkins-Kennedy test was X. Painful Arc test was X. Shoulder Adduction test (Dugas) was X. Speed's test was X. Active range of motion of the lumbar spine showed flexion was X degrees, extension was X degrees, right lateral flexion was X degrees, and left lateral flexion was X degrees. Active range of motion of the right shoulder revealed flexion was X degrees, extension was X degrees, abduction was X degrees, adduction was X degrees, internal rotation was X degrees, and external rotation was X degrees. Left shoulder active range of motion demonstrated flexion was X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation was X degrees, and external rotation was X degrees. The hand dynamometer examination on the right revealed: X. Rapid exchange grip test of the right hand showed X. The functional capacity evaluation results were as follows: X occupation was as a X. X job-required physical demand level (PDL) was X. At the time, X was performing at a Sedentary to Light PDL as per NIOSH Standards. The functional capacity evaluation deficit analysis was as follows: 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 related to meeting the standing (currently occasional

versus constant job requirement), walking (currently occasional versus constant job requirement), bending (currently occasional versus frequent job requirement), reaching overhead (currently occasional versus frequent job requirement), reaching out (currently occasional versus constant job requirement), climbing (currently infrequent versus frequent job requirement), squatting (currently infrequent versus frequent job requirement), kneeling (currently infrequent versus frequent job requirement), floor lifting (currently X pounds versus X pounds job requirement), floor to shoulder lifting (currently X pounds versus X pounds job requirement), floor to overhead lifting (currently X pounds versus X pounds job requirement), two hand carrying (currently X pounds versus X pounds job requirement), pushing (currently X pounds versus X pounds force required job requirement) and pulling (currently X pounds versus X pounds force required job requirement) job criteria as defined by the Dictionary of Occupational Titles and/or X Job Description Interview. It was noted that X had completed X: bending (from infrequent to occasional). X had demonstrated the following regressions: floor lifting (from X pounds to X pounds), floor to shoulder lifting (from X pounds to X pounds) and two hand carrying (from X pounds to X pounds). X mental health evaluation dated X, revealed a PHQ-X of X(X on X, X on X indicating moderate depression, GAD-X of X(X on X,X on X) indicating moderate anxiety, FABQPA of X (X on X, X on X) and a FABQWP of X (X on X, X on X) indicating continued, but improved 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 had struggled with regard to 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, especially toward the latter stages of X work hardening program when the volume of X workload was increased. This evidenced psychologically by increased depression and anxiety and physiologically by increased VAS sitting and standing, increased heart rate sitting and standing, increased rating of perceived exertion (RPE) and decreased functional abilities all due to increased pain. Based on the results of this exam and considering the X mental health evaluation, Dr. X agreed with the recommendation of the mental health evaluation 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.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, DC, the request for X was denied. Rationale: “Regarding X, the ODG states that X may be recommended when all underlying causes have been assessed and treated (eg, fracture, infection), appropriate pain condition for rehabilitation is present as indicated by pain with evidence of loss of function that persists beyond X weeks along with presence of risk factors that increase likelihood of transition to chronic pain, as indicated by belief that pain is due to progressive pathology or that pain is harmful or severely disabling, development of X have not been successful in alleviating pain. Clinical history should consist of X or more of the following: no previous X for same condition or injury, or recent change of symptoms or function in patient with previously stable chronic pain. Level of care is appropriate, as indicated by X. There should be no X. Patients should be X. X programs typically offer part-time (X days per week) or full-time (X days per week) programs with an average total treatment time of approximately X weeks. X duration should generally not exceed X weeks, with the first X days effectively constituting an evaluation period. Extensions beyond this require rationale for the extension, an individualized care plan including clear attainable goals, and evidence of documented improvement from the facility. The request is not supported. Based on the records, the claimant continued to experience a severe functional deficit which did not allow them to meet job requirements. The provider

noted that the claimant had demonstrated an increase in their physical and functional abilities during the X, however struggled with regard to mental barriers. A X was requested to address the claimant's continued moderate depression and increased anxiety. Per the psychological evaluation on X, the claimant had increased Patient Health Questionnaire (PHQ X, General Anxiety Disorder Test (GAD), and Fear-Avoidance Beliefs Questionnaire (FABQ), scores from the prior X. Thus, given persistent/worsening symptoms despite X, the request for X is not reasonable or warranted and do not align with guideline recommendations. Any treatment in any one of the X would preclude the use of another program. Guidelines do not support reenrollment into same or similar programs for the same work condition. As such, the request cannot be certified. Telephone contact was established. Dr. X confirmed that the claimant completed X. At this point in plateau, there is no new intervening event to support transition into or re-enrollment into another form of X. Therefore, the request X, per X order is non-certified."

On X, Dr. X wrote an appeal request for denial of the requested services of X stating, "A request for X was non-certified by the peer review doctor due to the following: "Thus, given the persistent/worsening symptoms despite other X, including X is not reasonable or warranted and do not align with guideline recommendations. Any treatment in any one of the X would preclude the use of another program. Guidelines do no support re-enrollment into same or similar programs for the same work conditions. As such, the request cannot be certified.'' Regarding the non-certification: First. The claimant started at a Sedentary to Sedentary-Light PDL and finished the X at a Sedentary to Light PDL. So even though the claimant demonstrated some regression during the X, X still performed at a higher PDL than when X started. Second. Considering the claimant's MOI, it is not surprising that X demonstrated increased anxiety and depression when X pain increased with increased load as well as increased fear-avoidance when performing the increased activity and loads. Third. The ODG states the following for X: X. In this particular case, although X has participated in a previous X, X experienced a recent change in symptoms, ie increased pain and decreased function from a previously stable condition. Therefore, we request an appeal and reconsideration for X."

Per a reconsideration review adverse determination letter dated X by X, DC, the request for X was denied. Rationale: “The Official Disability Guidelines indicate that X was designed to use a X. The guidelines indicated that post program treatments are recommended for medication management that is well documented, especially for patients identified as having substance abuse issues to avoid continued addiction or relapse; or, treatment requests that are well documented (eg, defined goals, interventions, planned treatment duration) and given to referring physician for further consideration. The medical records submitted for review indicated that the claimant had X. The claimant demonstrated increased anxiety and depression when the pain increased with increased load as well as increased fear-avoidance when performing the increased activity and loads. In this case, although an appeal narrative was submitted indicating progress and regression of symptoms, the medical necessity has not been established. The report failed to highlight any significant functional improvement/benefits, improvement in activities of daily living, psychosocial improvements of the claimant, reduction on medication use, and return to work plan or other productive activities to consider another X. Partial certification or modification of the whole review was not permitted in this state jurisdiction without a successful peer-to-peer discussion and consensus. As such, the request for X, per X order is not supported. Recommended for noncertification.”

Thoroughly reviewed provided records including provider notes and peer reviews.

Valid reasoning for request for X were given in original documentation and emphasized directly in appeal letter. The patient had significant functional and objective improvements from X but is still needing higher physical capacity to successfully return to work. Thus, continued X is necessary. X, per X order 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.

Valid reasoning for request for X were given in original documentation and

emphasized directly in appeal letter. The patient had significant functional and objective improvements from X but is still needing higher physical capacity to successfully return to work. Thus, continued X is necessary. X, per X order is medically necessary and certified

Overturned

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