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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, while working as a X. X stated, X. The diagnoses were (X) sprain of unspecified parts of right shoulder girdle, subsequent encounter; (X) other sprain of left hip, subsequent encounter; (X) sprain of other specified parts of left knee, subsequent encounter; other injury of liver, subsequent encounter; other specified anxiety disorders, (X) sprain of ligaments of cervical spine, subsequent encounter; and (X) sprain of ligaments of lumbar spine, subsequent encounter. On X, X was seen by X, MD, complaining of low back pain. The pain radiated into the left lower extremity. X was able to stand for less than X minutes, able to sit for less than X minutes and able to walk for less than X minutes. At the time, pain level was X, at the worst it was X, and at the best, it was X. The pain onset was associated with a specific event – work-related injury. X was a X. At the time, X was not working. The pain was described as shooting, aching, burning, and constant. It was made better by nothing. It was made worse by standing, sitting, and walking. On examination, blood pressure was 149/101 mmHg. X was using a walker to walk. X could not walk on toes or heels. X had facet pain on spine rotation / extension / flexion and palpation and axial loading. Straight leg raising test was X. Pain in the lumbar facets was X. Waddell's sign was positive. The functional capacity evaluation (FCE) and psychiatric evaluation for chronic pain program was

recommended. Per a Functional Capacity Evaluation dated X, X was evaluated by X X, for X ongoing complaints. The purpose of this Baseline Functional Capacity Evaluation was to determine X overall musculoskeletal and functional abilities as it related to the physical demands outlined by the United States Department of Labor in the Dictionary of Occupational Titles. At the time, X was out of work. At that time, X reported being in an injury due to X. X was taken to X. X reported feeling tremendous pain. X saw Dr. X, Dr. X for X injury. X reported all activities of daily living were still a challenge as well as standing / sitting for prolonged caused burning to and extra pain. X reported X was using many modalities decrease pain. X reported X was needing to improve because X was alone. At the time, the ongoing pain was X, least pain was X, average pain was X and worst pain was X. On examination, X blood pressure was 158/92 mmHg, heart rate was 113 beats per minutes and weight was 325 pounds. Lumbar range of motion showed flexion was X degrees, extension zero (X) degrees, right lateral flexion was X degrees, left lateral flexion was X degrees, straight leg raise on the left was X degrees and straight leg raise on the right was X degrees. Left lower extremity active range of motion (AROM) showed hip flexion was X degrees, hip extension was X degrees, hip adduction was X degrees, hip abduction was X degrees, knee flexion was X degrees, and knee extension was X degrees. Right upper extremity AROM showed shoulder flexion was X degrees, shoulder extension was X degrees, shoulder adduction was X degrees, shoulder abduction was X degrees, horizontal adduction was X degrees, horizontal abduction was X degrees, internal

rotation was X degrees and external rotation was X degrees. The Oswestry Low Back Disability Questionnaire was performed, and X scored at a X which would suggest crippled. Back pain impinged on all aspects of X life, both at home and at work, and positive intervention was required. This level may suggest the potential for unreliable pain reports during functional testing. X demonstrated the ability during fine motor coordination testing to be able to perform this activity on an OCCASIONAL basis. X demonstrated the ability during gross motor coordination testing to be able to perform this activity on an OCCASIONAL basis. X demonstrated the ability during walking testing, to perform this activity on an AVOID basis. X demonstrated the ability during forward reaching testing, to be able to perform this activity on an AVOID basis. X demonstrated the ability during above shoulder reaching testing, to be able to perform this activity on an AVOID basis. X demonstrated the ability during repetitive squatting testing, to be able to perform this activity on an AVOID basis. X reported being dizzy throughout the test. On Occasional Bilateral Squat Lifting testing, X demonstrated the ability to lift (X) zero pounds from floor to waist. During Occasional Pushing testing, X demonstrated the ability to push (X) zero horizontal force pounds for X feet. During Occasional Pulling testing, X demonstrated the ability to pull zero (X) horizontal force pounds for X feet. X demonstrated the ability to perform sitting on a FREQUENT basis and standing on a FREQUENT basis. Regarding X functional abilities to job demands, this job specific evaluation was performed in a X kinesiophysical approach, and X demonstrated the ability to perform X of the physical demands of X job as a X.

The return-to-work test items, X was unable to achieve successfully during this evaluation included: occasional squat lifting, occasional power lifting, occasional shoulder lifting, occasional pushing, occasional pulling, gross motor coordination, pinching, squatting, sustained squatting, walking, forward reaching, above shoulder reaching, stair climbing, static balance up off of the ground, dynamic balance up off of the ground and sitting. X demonstrated the ability to perform within the SEDENTARY Physical Demand Category. X job as a X was classified within the MEDIUM Physical Demand Category. In summary, X performed while reporting a pain level of X according to Occupro Pain Scale and required immediate hospitalization. X performed with limiting factors: increased pain, client anxiety, client terminated, evaluator stopped, and safety concern. During this evaluation, X was unable to achieve X of the physical demands of X job / occupation. On X, X was seen by X, MA, LPC Associate /X, PhD, for behavioral evaluation for X ongoing complaints. At the time, X was out of work. X was referred by Dr. X regarding treatment planning, in particular whether referral for X. This included the administration of an interview with X and several assessments to determine if X was X. The history of injury included the fact that X had sustained a work-related injury on X while working as an X. X reported that X was X. X reported X started X. X reported X was seeing Dr. X and Dr. X for X work-related injury. X reported X had received several levels of treatment including: X. Since the work-related injury, X psychophysiological condition had been preventing X from acquiring the level of stability needed to adjust to the injury,

manage X pain more effectively, and improve X level of functioning. X psychological symptoms appeared to be marked by the following: increased appetite, sadness, increased sleep/insomnia, energy decrease, frustration, irritability, inability to get pleasure out of life, increased sensitivity, become emotional more easily; crying episodes, decrease in libido, discouragement about the future, feelings of inadequacy, not able to relax, muscle tension, difficulties in adjusting to injury, panic, rapid heart rate, nervousness, fear of re-injury, concentration difficulties, and increased concerns about physical health. X reported X was being treated for high blood pressure. X denied taking medication for mood disorders. X denied any ongoing psychiatric treatment or problems. X denied suicidal ideations and attempts in the past or present. X indicated having mental health inpatient treatment in the past. X denied outpatient mental health treatment. X denied hypomanic episodes, delusions, hallucinations, and paranoia. X reported X was receiving Workers' Compensation income benefits and that X finances were stressful, that X was always worried about X finances. Regarding ongoing complaints, X reported during the interview that the primary location of X pain was in X back, left hip, and right shoulder. X reported having numbness in both legs and got dizzy. X used the following words to describe the pain which X experienced since the injury: constant, sharp, shooting, numbness, pins and needles, and tingling. X rated X pain level at a "X" (based on the VAS scale from 0-10) on an average day. X reported that X pain at times could flare up to a level "X" (based on the VAS scale from X) on X worst days, and get down to a level

"X" on X best days. Activities that X reported increased pain included: walking and sitting. The only things which X reported decreased X level of pain were lying down with a pillow on X back. X reported that pain interfered in X daily life and X could not do much. X reported sleeping about X hours per night, waking up on and off due to nightmares. X reported having trouble staying asleep. X reported no physical activity at home, just walking to the bathroom. X reported that the more active X was, the more X pain seemed to increase. X reported X was unable to do much due to X work-related injury. X reported X felt scared X would fall and hurt X. X reported X biggest worry was "will this pain ever stop and X." X expressed a desire to learn how to manage and lower X pain and get back to work. Regarding ongoing mental / emotional complaints, X reported X had difficulty managing X pain and experienced some interference with activities of daily living due to X pain and difficulties in adjusting to X injury. X reported X experienced symptoms of frustration, sadness, muscle tension, fear of re-injury, and increased concerns with X physical health. X was also experiencing stress regarding the treatment process of X injury. X was under emotional distress and had many feelings that X had not expressed or explored. X had tried to remain as active as possible; however, was having difficulty coping with X recurrent pain and adjustment difficulties relating to X injury. On the Beck Depression Inventory II (BDI-X), X scored a X within the moderate range of depression. On the Beck Anxiety Inventory (BAI), X scored a X, within the severe range of the assessment. X was administered the Screener and Opioid Assessment for Patients in

Pain-Revised (SOAPP-R) and scored a X, indicating a X. The Fear Avoidance Beliefs Questionnaire (FABQ) was developed to investigate fear avoidance beliefs among LBP patients in the clinical setting; work scale was X (*High) and activity scale was X (*High). The mental status examination revealed X. X was medium height and heavy build. X appeared neat and clean and seemed X stated age of X. X was cooperative, open, and friendly during the interview. X seemed to have a mild problem with orientation, attention span, distractibility, and frustration tolerance. This interview was conducted in English. X native language was English. X speech was normal in speed and normal in volume. Speech content was fluid. Thought processes were coherent and goal-directed. Mood seemed depressed. X affect was congruent to mood. X displayed good eye contact during the interview. It was noted that X had not been able to become stabilized enough to enhance coping mechanisms to more effectively manage pain and achieve success in rehabilitation. X was requesting to participate in X. Without this type of intensive intervention, X maladaptive beliefs and thoughts were likely to continue in a downward spiral as the chronic pain continued to affect X quality of life. This program was composed of a multidisciplinary team of professionals that were specifically trained to address X needs (e.g., fears and irrational beliefs and thoughts), which were not met through psychotherapy. X met the criteria for the general use of multidisciplinary pain management program, according to Official Disability Guidelines, chronic pain chapter. In summary, X pain was resulting from X injury and had severely impacted normal functioning physically

and interpersonally. X reported frustration and stress related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain had reported high stress resulting in all major life areas. X would benefit from a course of pain management. It would improve X ability to cope with pain, anxiety, frustration, and stressors, which appeared to be impacting X daily functioning. X should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. The program was staffed with multidisciplinary professionals trained in treating chronic pain. The program consisted of, but was not limited to, daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services would address the ongoing problems of coping, adjusting, and returning to a higher level of functioning as possible. Per a progress summary dated X completed by X, MA, LPC Associate / X, PhD, X began attending the X. X had X. The request was for an X. Regarding behavioral observations, it was noted that X was beginning to recognize and putting into practice the learned natural restorative techniques to manage more effectively X stress, tension, and pain. X had been compliant with the program and seemed to accept X accident and injury. At that time, pain symptoms still appeared to be impairing work, social and personal functioning; however, X was making some progress in X ability to cope with these pain-related symptoms. Continued care for psychological factors and continued consistency with the program were important for X to continue acquiring and

maintaining the long-lasting meaningful changes, which would improve X level of functioning. Since X date of injury on X, X seemed to have been suffering from muscular tension and had since developed chronic pain symptoms. X reported that the pain program had helped X become aware of X adjustment difficulties and realize that X did need some support to help overcome X fears and difficulties with pain and functioning. Some of X stressors still included the amount of time which it had been taking for X to recover from the physical injury and dealing with X feelings of being out of control and helpless during life's most basic tasks. X stated that X pain was consistent and X level of functioning was still a struggle but that X was learning to pace herself with activity; X was beginning to learn more self-management techniques which make it easier for X to adjust to or control this pain and stress. X appeared positive and motivated to manage X pain and get better. X shared well in group sessions. X seemed to be struggling with X moods and depression related to X situation. X participated well in therapy and was open in group sessions. X reported X was writing and compliant with X pain journal and also did meditation at home. X reported that "emotionally," X felt a little better than before the program and felt like X was managing X emotions with pain better. The physical report stated X was unable to complete the squat lift, shoulder lift, unilateral lift, and unilateral carry due to reported inadequate strength to bend down to reach floor level and due to reported need for holding onto assistive walking device. X had increased efforts to push and pull weight. X was at a sedentary level for power lift, and at the time, X was at Light. X

was at Sedentary and at the time, was at Medium for Push/Pull. X had increased X lumbar extension range of motion. X job demand category was MEDIUM and X was lifting in the LIGHT category. In addition, X previous complaint of lumbar pain with a forward bend had increased with reported more pain, numbness, burning, and tingling sensations. X reported X was "not getting any better than when X started" with regard to physical conditioning. X reported that upon entering the program, X was suffering from severe fear of future reinjury and other return to work concerns; however, after completion of approved sessions in the chronic pain program, X was continuing to understand that X fears were not only irrational in nature but also holding X back from a successful recovery. With the help of exercise and physical conditioning, X was getting closer to better functioning to go back to work. Before participating in the program, X was reporting that X levels of pain would average around a level "X" (based on the VAS scale from X). After several sessions of the X, X current average level of pain was at a "X" (based on the VAS scale from X). Regarding relaxation training, X had participated in various natural restorative processes, which seemed to improve X ability to lower stress reactions, reduce tension, more effectively manage pain, and improve X health due to X being absent every time this was done in sessions. X reported that X was doing deep breathing and meditations at home. The additional X would allow X to add meditations teamed in the program at home and to be consistent with them. Regarding coping skills training, several topics had been presented to X in an effort to expand X knowledge of X, X self-esteem, X self-

confidence. and X coping skills. The exercises and techniques learned in these group psychotherapy sessions provided X with the tools X needed to learn to adjust and live with X chronic pain more effectively. At the time, X was performing physical activities, and was able to perform cardiovascular activity on the stationary bicycle for X minutes at X miles and was unable to perform exercise on the treadmill because X reported a high pain level and safety concern when X leg "goes numb". X was able to lift X pounds by starting in a low bend/squatting position. X was unable to complete the squat lift, shoulder lift, unilateral lift, and unilateral carry due to reported inadequate strength to bend down to reach floor level and due to reported need for holding onto assistive walking device. X had increased efforts to push and pull weight. X was at a sedentary level for power lift and at the time, at Light. X was at Sedentary and at the time, X was at Medium for Push/Pull. X had increased X lumbar extension range of motion. X job demand category was MEDIUM and X was lifting in the LIGHT category. In addition, X previous complaint of lumbar pain with a forward bend had increased with reported more pain, numbness, burning, and tingling sensations. X reported X was "not getting any better than when X started" in regards to the physical conditioning. After completion of sessions in the X was once again administered the Beck Depression Inventory II (BDI-II) and scored a X. After completion of sessions in the X, X was once again administered the Beck Anxiety. Inventory (BAI) and scored a X. In summary, X was continuing to progress toward X goals and ability to improve in the daily activities of X life. X was willing to share X thoughts with the

group members. Additional sessions would help X form a routine and schedule. X was learning adequate coping mechanisms to deal with the multifaceted deficits that are occurring as a response to X injury. X would benefit with continued group sessions to better manage and use X coping skills. Additional sessions were absolutely necessary to the motivation and education X was receiving, which were helping X to redefine X life and return X to optimal functioning. At the time, X were recommended. The X. An MRI of the lumbar spine dated X revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, PhD, the request for X, was denied. Rationale: “The patient has made minimal to no progress in the program according to data presented by requestor. Further, the patient states X is not getting any better. Medical necessity is not established for X. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X, was denied. Rationale: “The Official Disability Guidelines conditionally recommend functional restoration programs for individuals with chronic disabling pain. In this case, the records indicated that the claimant has been consistent in attending X. The provider noted that the claimant is unable to complete squat lift, shoulder lift, unilateral lift and unilateral carry due to reported inadequate strength to bend down to reach floor level and need for holding onto assistive walking device. Prior treatments include unknown duration of X. Despite treatments, it was noted that pain symptoms still appear to be impairing work, social and personal functioning but making some progress in the ability to cope with these pain-related symptoms.

The claimant was at a sedentary level and is now at light for power lift and medium for push / pull. The claimant's Beck Depression Inventory score was X and after completion of sessions in the program, the score was X. The claimant's Beck Anxiety Inventory was X and after completion of program session, the score was X. The treating provider recommends an X. However, there are only minimal gains reported. There is no evidence of significant demonstrated efficacy as documented by subjective and objective gains. The records do not support that the claimant would meet their goals with ongoing treatment. As such, the medical necessity has not been established for the request for Reconsideration X. "Thoroughly reviewed provided records including provider notes and peer reviews. The patient has had X. There has been improvement in objective measures as well. Thus, X is warranted. 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 has had X. There has been improvement in objective measures as well. Thus, continued X is warranted. 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)**