Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: @independentresolutions.com

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 reported X." X reported having an adrenaline rush and felt pain afterwards toward the end of X shift X. The diagnosis was strain of muscle, fascia and tendon of left hip, initial encounter (X).

X underwent a functional capacity evaluation (FCE) by X, NASM-CPT, on X. 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. This job specific evaluation was performed in a 100% kinesiophysical approach and X demonstrated the ability to perform 12.2% 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, Frequent Squat Lifting, Occasional Power Lifting, Occasional Shoulder Lifting, Frequent Shoulder Lifting, Occasional Overhead Lifting, Occasional Bilateral Carrying, Frequent Bilateral Carrying, Occasional Unilateral Carrying, Frequent Unilateral Carrying, Occasional Pushing, Occasional Pulling, Gross Motor Coordination, Firm Grasping, Bending, Squatting, Sustained Squatting, Kneeling Sustained, Kneeling Repetitive, Walking, Forward Reaching, Above Shoulder Reaching, Ladder/Other, Static Balance up off of the ground and Standing. X demonstrated the

ability to perform within the SEDENTARY Physical Demand Category based on the definitions developed by the US Department of Labor and outlined in the Dictionary of Occupational Titles, which was below X jobs demand category. Based on sitting and standing abilities, X may be able to work full time within the functional abilities outlined in this report. It should be noted that X job as a X was classified within the MEDIUM Physical Demand Category. During clinical functional testing, X demonstrated consistent effort throughout 37.5% of this test which would suggest significant observational and evidenced based contradictions resulting in consistency of effort discrepancies, self-limiting behaviors, and/or sub-maximal effort. The overall results of this evaluation do not represent a true and accurate representation of X overall physical capabilities. The functional results of this evaluation represent a minimal level of functioning for X. During clinical functional testing, the items that were inconsistent resulting in self-limiting behavior/sub-maximal effort included right hand grip strength inconsistencies, right five span grip inconsistencies, left five span grip inconsistencies, right five span versus right grip inconsistencies and left five span versus right grip inconsistencies. During clinical functional testing, X demonstrated consistent effort throughout 37.5% of this test which would suggest significant observational and evidenced based contradictions resulting in consistency of effort discrepancies, self-limiting behaviors, and/or sub-maximal effort. The overall results of this evaluation do not represent a true and accurate representation of X overall physical capabilities. The functional results of this evaluation represent a minimal level of functioning for X. During clinical functional testing, the items that were inconsistent resulting in self-limiting behavior/sub-maximal effort included right hand grip strength

inconsistencies, right five span grip inconsistencies, left five span grip inconsistencies, right five span versus right grip inconsistencies and left five span versus right grip inconsistencies. In summary, it was noted that X was unable to continue with material handling due to reported pain level of X on the OccuPro scale by definition: extremely disabling pain - you need to leave area and lay down with pain related tears. X reported escalating pain level as the test continued. X performed with limiting factors: safety concern, increased pain, inadequate strength, and loss of balance. During this evaluation, X was unable to achieve 100% of the physical demands of X job/occupation. The limiting factor(s) noted during these clinical functional tests included: Compensatory Techniques, Inadequate Strength, Increased Pain, Loss of Balance and Safety Concern. On X, X was evaluated by X, MD with respect to a work-related injury sustained while working for X on X. X reported X felt worse, with sharp, throbbing, X pain, constant pain, made worse by standing, walking, bending. Sitting and lying down made it better. X reported needle-like pain. Following the treatment plan, it did not help. X took X for X pain. X had received multiple sessions of X. Home exercise program had not helped. X was apparently doing X. X had MRIs. X had an episode last week of severe, X and X pain, which lasted about X minutes in the left hip. X did not go to the emergency room and it improved spontaneously. Examination noted left-sided greater trochanteric bursa pain. The assessment was strain of muscle, fascia and tendon of left hip, initial encounter (X). Dr. X noted that X was going to be reviewed the upcoming X for chronic pain program, after which X felt X would be at maximum medical improvement (MMI). Per a X, Dr. X noted that X medical condition would allow X to return to work as of X with restrictions as of X. The restrictions included no standing or walking

more than X hours per day, and no lifting or carrying objects more than X pounds per day. On X, X underwent a Behavioral Evaluation and Request for Services - Request for X, by X, MA / X, PhD / X, MD. X was referred by Dr. X for a behavioral evaluation and input was requested regarding treatment planning, in particular whether referral for X would be appropriate at that time. This included the administration of an interview with X and several assessments to determine if X was experiencing depression or anxiety or other mental health symptoms related to the injury, to determine whether or not X understood the purpose of and appropriate use of medications, and a mini-mental status examination. The following tests were administered: Clinical Interview; Beck Depression Inventory-II (BDI-II); Beck Anxiety Inventory (BAI); Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R); Fear Avoidance Beliefs Questionnaire (FABQ); and Mental Status Examination. X reported during the interview that the primary location of X pain was in X hip along X pant line. X reported the cold weather seemed to affect X pain. X used the following words to describe the pain which X experienced since the injury: constant, stabbing, sharp, and throbbing. X rated X pain level at a "X" (based on the VAS scale from X) on an average day. X reported 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: hip thrusts, stretches, standing, walking, bending, and running. X reported lying down decreased X level of pain. X reported pain interfered in X daily life and while driving X experienced pain, hurt when walking or standing which was essential to X daily life. X reported sleeping about X hours per night. X reported having difficulty falling asleep due to X pain. X reported resting about X hours per day. X

reported being physically active about X hours per week yoga and walking on X own. X reported that the more active X was, the more X pain seemed to increase. X reported arguing more with family and friends since X work-related injury. X reported X was unable to play volleyball, walk long in the park, or do Pilates due to X work-related injury. X reported X was physically active before X injury and at that time, X was staying home on the heating pad due to being in a lot of pain. X reported that X biggest worry was "will I ever be the same". X expressed a desire to learn how to manage and lower X pain and go back to work. X reported having difficulty managing X pain and experienced some interference with activities of daily living due to X pain and difficulties adjusting to X injury. X reported that X experienced symptoms of frustration, sadness, muscle tension, fear of re-injury, and increased concerns with X physical health. X also experienced 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, had difficulty coping with X recurrent pain and adjustment difficulties relating to X injury. On the Beck Depression Inventory II (BDI-II), X scored a X within the mild range of the assessment. On the Beck Anxiety Inventory (BAI), X scored a X, within the mild 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 low risk for abuse of prescribed narcotic pain medications. The Fear Avoidance Beliefs Questionnaire (FABQ) was administered to X and the following scores were received: Work scale = X out of X (high) and Activity scale = X out of X (high). Mental Status Examination revealed X was X minutes late for the appointment. X ambulated without assistance. X was a X of short height and heavy

build. X appeared neat and clean and seemed younger than X stated age of X. X was cooperative and friendly during the interview. X seemed oriented in all spheres. This interview was conducted in English which was X native language. X speech was normal in speed and normal in volume. Thought processes were coherent and goal-directed. Mood seemed euthymic. X affect was congruent to mood. X displayed good eye contact during the interview. The clinical rationale for the requested procedure(s) was as follows: Being that X had not been able to become stabilized enough to enhance coping mechanisms to more effectively manage pain and achieve success in rehabilitation, it was requested that X 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. It was crucial that X receive other necessary components, which were not provided in individual therapy, to help obtain the tools needed to succeed and increase overall level of functioning. The program was composed of a multidisciplinary team of professionals that were specifically trained to address the patient's needs (e.g., fears and irrational beliefs and thoughts), which were not met through psychotherapy. In the X, X would receive the tools needed to remove or address both psychological and physical barriers. X met the criteria for the general use of X. In summary, it was noted that the pain resulting from X injury 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. X had reported high stress resulting in all major life areas. X would benefit from a X. 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 X. The program was staffed with multidisciplinary professionals trained in treating X. 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.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, per X order was denied by X, MD. Rationale: "The Official Disability Guidelines would support X. Previous methods of treating chronic pain should be unsuccessful and a thorough multidisciplinary evaluation should be made. This claimant has complaints of chronic pain in the hip and back. However, progress notes do not indicate that symptoms are debilitating in any way or there is a reliance on others for care and withdrawal from normal social activities. Physical therapy and home exercise have not been beneficial. Physical examination is relatively unremarkable and only reveals tenderness at the left trochanteric bursa and piriformis, as well as mild pain at the left sacroiliac (SI) joint. Furthermore, a functional capacity evaluation reveals a submaximal effort which is suspect for secondary gain issues. A phone call to the office of X, MD at (X was placed on X at 10:29 AM CST. The provider was unavailable. However, a conversation was held with X, LPC, regarding the requested care. The claimant is treated for debilitating hips and low back pain. The discomfort ranges between X and X out of X.

They are currently living at home and rely on their parents for assistance. On physical examination, as noted previously, there are very few objective findings. A functional capacity evaluation was conducted, which noted poor effort during that examination. The claimant has been off work since X and is interested in returning to work. Unfortunately, due to the lack of significant objective findings, this request is not supported. For these multiple reasons, this request for participation in X is not supported. Thus, the request for X, per X order, is recommended for non-certification."

Per a letter of appeal dated X, by X, MA; X, PhD; X, MD, X was denied the X due to "not trying on the FCE" and "minimal physical findings - only tenderness". The Chronic Pain Management Program was for any type of pain that had become "chronic" - X months after injury and X continued to feel pain. Chronic pain meant that the nervous system may be misfiring and was in the biopsychosocial model, which meant many things could affect how X felt pain and this program would help X with physical conditioning and cognitive behavioral therapy (CBT) concurrently. As for the FCE: X FCE was performed with X putting forth good effort and self-pacing. This indicated decreased fluidity of movements necessary for proper function. X did not demonstrate "Submaximal Effort" and did not stop X with "Self-Limiting" behaviors. Both these terms were options to select as primary limiting factors during the FCE and neither were selected by the therapist. X primary limiting factors were safety concern, increased pain, inadequate strength, and loss of balance. These factors as a group contributed to the "Avoid" and zero pounds of PDL of X FCE, not, client termination. X met ODG, per the records. X was a young adult and X life was basically

"on hold" as X reported having to lie on a heating pad most days. X would like to get back to work and on with X life learning how to work through and manage X pain.

Per a reconsideration review adverse determination letter dated X, the appeal request for X, per X order, was denied by X, MD. Rationale: "Based on the medical records, comorbidities are found in the record to include stroke and a body mass index (BMI) of 37.02 kg/m2. Prior treatment included X without benefit, per utilization review, and medications that helped with severe pain. According to the behavioral evaluation by MA X/Ph.D. X/Dr. X on X, the claimant complained of constant, stabbing, sharp, and throbbing hip pain along the pant line rated X on an average day, flareup to X on a worst day, and X on a best day. The cold weather seemed to affect the pain. Activities that reported increased pain included hip thrusts, stretches, standing, walking, bending, and running. The level of pain was decreased when the claimant laid down. The pain interfered with their daily life, there was pain with driving as well as pain with walking/standing which was essential to their daily life. They reported sleeping about X hours per night and resting X hours per day. They reported being physically active about X hours per week with yoga and walking on their own. The more active they were, the more the pain seemed to increase. They argued more with family and friends since their work-related injury. They were physically active before the injury and now they were staying home on the heating pad due to being in a lot of pain. Their biggest worry was whether they would ever be the same. They expressed a desire to learn how to manage and lower the pain and go back to work. They experienced symptoms of frustration, sadness, muscle tension, fear of

re-injury, increased concerns about their physical health, and stress regarding the treatment process of their injury. Additional psychological symptoms included decreased appetite, insomnia, frustration, irritability, inability to get pleasure out of life, crying episodes, discouragement about the future, inability to relax, nervousness, and concentration difficulties. The claimant had tried to remain as active as possible; however, they had difficulty coping with the recurrent pain and adjustment difficulties relating to the injury. The mental status exam was unremarkable. The Beck Depression Inventory-II score was X, within the mild range of the assessment. The Beck Anxiety Inventory score was X, within the mild range of the assessment. The screener and opioid assessment for patients in pain-revised score was X, indicating a low risk for abuse of prescribed narcotic pain medications. The fear avoidance beliefs questionnaire score was a work scale of X out of X(high) and an activity scale of X out of X (high). The diagnosis was not documented. The treatment plan included a course in pain management to improve their ability to cope with pain, anxiety, frustration, and stressors, which appeared to be impacting daily functioning. A functional capacity evaluation dated X, by CPT X/Dr. X documented the claimant demonstrated the ability to perform within the sedentary physical demand category. During objective functional testing, the items that were inconsistent resulted in self-limiting behaviors/sub-maximal effort including right hand grip strength inconsistencies, right five span grip inconsistencies, left five span grip inconsistencies, right five span versus right grip inconsistencies and left five span versus right grip inconsistencies. Per the utilization review by Dr. X on X, the request for X, per the X order, was non-certified as progress note did not indicate that symptoms were debilitating in any way or there was a reliance on

others for care and withdrawal from normal social activities. Additionally, the physical examination revealed very few objective findings, and the functional capacity evaluation noted poor effort. For these multiple reasons, this request for participation in a X was not supported. A pre-certification request by Dr. X was submitted on X, for X. An appeal letter by X on X, indicated that the claimant was non-certified for the X due to not trying on the functional capacity evaluation and minimal physical exam findings- only tenderness. According to the provider, the claimant continued to feel pain and their injury was now chronic. A functional capacity evaluation was performed with them putting forth good effort and self-pacing. This indicated decreased fluidity of movements necessary for proper function. The claimant did not demonstrate submaximal effort and did not stop themselves with self-limiting behaviors. Both these terms were options to select as the primary limiting factors during the functional capacity evaluation and neither were selected by the therapist. The claimant's primary limiting factors were safety concerns, increased pain, inadequate strength, and loss of balance. These factors as a group contributed to the avoid and zero pounds of physical demand level of their functional capacity evaluation, not client termination. The claimant would like to get back to work and on with their life learning how to work through and manage their pain. The Official Disability Guidelines (ODG) states that X are considered medically necessary for patients with chronic pain syndromes lasting over three months, exhibiting functional loss and at least three of several criteria including healthcare dependence, physical deconditioning, social withdrawal, failure to restore pre-injury function, psychosocial sequelae, continued prescription pain medication use without improvement, and when other treatment options have failed.

These programs require a thorough multidisciplinary evaluation including physical, psychological, social, and vocational assessments, and must demonstrate a treatment plan with measurable outcomes, patient motivation, and address potential substance abuse issues. Treatment duration is generally limited to four weeks, with extensions requiring clear justification and evidence of efficacy, and reenrollment for the same condition is typically not warranted. Post-treatment plans, including medication management and addiction follow-up, are essential for sustained improvement. Total treatment duration should generally not exceed X weeks (X full-days or X hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. The request is not supported. There is insufficient documentation of trials and failure of adequate conservative treatments corroborated by therapy and procedure notes to support the request. Additionally, there was no documentation that an adequate and thorough multidisciplinary evaluation including physical, psychological, social, and vocational assessments had been made and only an FCE was done, as per the guidelines. Moreover, there is insufficient documentation of the objective findings to determine the claimant's ongoing deficits to support the request. Finally, there was a lack of consistent effort throughout this test, indicating self-limiting behaviors and submaximal effort. No exceptional factors were identified to override the previous determination. A phone call to the office of X at X was attempted on X at 9:10am CST to discuss the requested care. The provider was unavailable. However, a conversation was held with X, MA regarding the requested care. They say that there were X sessions of physical therapy (PT) that were missing from the original file, and they will be faxing them. Otherwise, the claimant has not had other

conservative therapies as they were denied procedural interventions. Since the documents are not here for review, the request for X order is non-certified.

Thoroughly reviewed provided records including provider notes and peer reviews.

Documentation provided reveals extensive use of conservative treatment such as physical therapy and medications. The patient later had through evaluation prior to request for X. While the cited guidelines have substantial prerequisites for participation in such a program, the documentation provided supports an initial request for 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 provided records including provider notes and peer reviews.

Documentation provided reveals extensive use of conservative treatment such as physical therapy and medications. The patient later had through evaluation prior to request for X. While the cited guidelines have substantial prerequisites for participation in such a program, the documentation provided supports an initial request for X. X is medically necessary and certified

Overturned

Independent Resolutions Inc.

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Case Number: X Date of Notice: X:Amendment X

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

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☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE