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***Notice of Independent Review Decision***

**IRO REVIEWER REPORT**

**Date:** X; Amendment 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 at work on X. X reported X was involved in a X. The diagnosis was tear of right acetabular labrum, initial encounter (X); status post right hip replacement (X); and strain of right hip (X). On X, X underwent a Physical Performance Evaluation (PPE) by X, DC. X demonstrated X. As noted during this evaluation, X was tested and was not able to achieve physical demand level (PDL). X maintained a positive attitude and willingness to return to normal activities of daily living and normal work-related activities, despite X ongoing limited abilities. X was cooperative throughout the entire evaluation and appeared to give genuine effort. Based on the history and exam findings, it was the opinion of Dr. X that X was able to perform a current physical demand level of LIGHT. X did not meet the physical demand level required for the position of employment where X was injured. X continued to have difficulty coping with the pain related to this injury. X also continued to demonstrate de-conditioning during the work activities of reaching up, reaching forward, bending and squatting; and during the work postures of sitting, standing, and walking. X also demonstrated decreased grip / pinch strength, instability of stance / gait, and range of motion. X would likely benefit significantly from X to aid X in effectively coping with the continued pain and increasing X overall functionality. X would need X 1. To increase strength and stability of the Right Hip. 2. To increase the ability, endurance, and body mechanics to perform activities of daily living and work-related activities. 3. To increase in strength during dynamic Box lifting at all levels. 4. To increase in ability of performing reaching up, reaching forward, bending, and squatting to constant. 5. Range of motion of all injured levels are not measuring within functional limits. 6. Patient is not currently conditioned to perform an X-hour work day. 7. Patient has continued reduction in their ability to perform activities of daily living. 8. Previous methods of X have been unsuccessful and there is an absence of other options likely to

result in significant clinical improvement. Progress Notes dated X, by X, APRN / X, MD, were documented. X presented for a chronic condition follow-up focused on X right hip pain. X described X pain as holding steady at a level of X out of X, noting that it has increased slightly since X stopped working out. Despite this recent uptick, X emphasized that the pain is not as severe as it was previously, suggesting some improvement over time. X added X had not had burning of the muscle, but had shooting pain down the right leg. X had been actively monitoring X pain levels and recognized that reduced exercise had contributed to the increase in discomfort. These details reflected X ongoing efforts to manage X chronic hip pain and adapted X activity level accordingly. Right hip examination revealed X. Range of motion was full, with right hip extension X degrees and flexion X degrees. The assessment was X. X were refilled. X was continued. X was continued on a light medium work duty status, with maximum lifts X pounds, X hours daily. X could bend, stoop, twist, push, pull, and carry X hours a day. X was restricted from X. X underwent a behavioral health evaluation by X, PhD, on X, The purpose of evaluation was to determine X. X reported that on X, X was involved in an X that caused injury to X right hip. X had participated in X. X had right X. X described X pain as continuous and ranging from X. X felt X pain had improved significantly with X. X was prescribed X for pain. X described these medications as helpful. X said X was able to perform most of the activities that X wanted and needed to do. X felt X injury / pain conditions were causing an overall decrease in social interaction. X reported the individual counseling X did during the X. The assessments administered included: Mankoski Pain Scale; Beck Depression Inventory – 2 (BDI-2); Beck Anxiety Inventory – (BAI); Short Form McGill Pain Questionnaire (McGill); Fear Avoidance Beliefs Questionnaire (FABQ); Pain Catastrophizing Scale (PCS); Short Form Health Survey (SF-36); Battery of Health Improvement 2 (BHI-2). On the Mankoski, X reported a pain level of X (moderate) on a scale of X. On the BDI-2, X scored a X, which is minimal for X. On the BAI, X scored a X, which is minimal for X.

On the McGill, X scored X for sensory pain complaints and X for affective pain complaints for a total score = X. On the FABQ, X scored X for activity which is not considered significant for fear of activity. X scored X for Work which is not considered significant for fear of work activity. On the PCS, X scored X, which is not considered significant for catastrophizing about pain. On the SF-36 measure, the following scale was indicated: Pain (X). The BHI-2 indicated X profile had X. It was noted there were no indications of secondary gain and there did not appear to be any stakeholders who would have interest in X not returning to work. X expressed X motivation to improve and was willing to change X medication regimen if recommended by the physician. X understood that a change in X condition could lead to a change in eligibility for income benefits. X goals for treatment were to increase X overall functional abilities, reduce pain, and return to work. It was recommended that X participate in a X and noted that X met the following generally accepted criteria for referral to a X: X was likely to benefit from the program. Pain interfered with physical, behavioral-health, social, recreational, and social functioning. Inability or perceived inability to work. Development of psychosocial sequelae that limited function or recovery after the initial incident including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behavior. Emotional / behavioral symptoms currently limited X successful return to work (RTW), but were expected to be well-managed through the course of the program. The diagnosis was not primarily a X. X-rays of the right hip dated X, demonstrated X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Proceeding with the X is not indicated at the time. The claimant is experiencing chronic right hip pain rated X despite X. Though a recent right hip physical exam revealed X. The claimant's gait was X. Additionally, the claimant has already undergone X. The Official Disability Guidelines recommend the program when there is pain with evidence of loss of function that persists beyond X weeks

and a clinical history that consists of no previous multidisciplinary pain rehabilitation for the same condition or injury. The claimant does not meet the guidelines' recommendations. As such, the request for X is non-certified." In a letter dated X, Dr. X documented a formal appeal for reconsideration for X. Dr. X wrote regarding the summary and justification for the appeal, "The denial of care is based on factual inaccuracies and a flawed clinical rationale. X is a X with X months of documented chronic pain post-injury. X has X. This history defines a treatment plateau and confirms that lower-level interventions are insufficient. X has persistent, X. The denial is arbitrary, contradicts the entirety of the objective medical evidence, and relies on cherry-picked data. Given the overwhelming objective evidence, we request prompt authorization for this medically necessary X. The enclosed documentation fully supports this request. "Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The Official Disability Guidelines recommend X. X may be recommended for initial therapy when all of the following are present, including underlying causes have been assessed and treated, appropriate pain condition for rehabilitation by pain with evidence of loss of function that persists beyond X weeks, clinical history consists of no previous multidisciplinary pain rehabilitation for same condition or injury or recent change of symptoms or function in patient with previously stable chronic pain, level of care is appropriate, no untreated psychiatric illnesses and patient is motivated and expected to be able to adequately participate in and respond as planned to proposed treatment. Outpatient 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. In this case, the claimant is complaining of chronic pain. Psychological evaluation noted X. Functional capacity evaluation revealed X. Prior treatments were X. The physician recommended X. Treatment goals and services were included in the report. This request was previously noncertified due to recent

right hip physical exam did not reveal X. Additionally, the claimant has X. The physician sent an appeal stating that X. The X provided insufficient results and they want to escalate to X. The physical exam on X does not invalidate the findings of the functional capacity evaluation which noted evidence of functional limitations. However, the guideline stated that there should be X. The claimant has X. X is a multidisciplinary pain rehabilitation program. Upon completion of any X is medically warranted for the same condition or injury. Thus, the request for X is noncertified. Peer to peer was unsuccessful. "In a letter of request for Independent Review (IRO), dated X, Dr. X wrote, "In summary, X case is the definition of medical necessity for a X. X has: 1. Failed an exhaustive list of lesser, uni-disciplinary interventions, including major surgery, X, and X. 2. Persistent, X. 3. Clear psychosocial barriers that are preventing recovery, as confirmed by Dr. X. The denial rests on a misapplication of the very guidelines it cites. We respectfully urge you to reverse this erroneous denial and authorize the X, which represents the next appropriate and necessary level of care for this patient."

**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. Patient is being treated for X. They have had extensive interventions discussed above. While the patient has already had X. In addition, continued X. Thus, the request for X is medically necessary and certified.

Certified.

**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)**