Vanguard MedReview, Inc.
101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work XX Program Daily x XX weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a Board-Certified Doctor of Orthopedic Surgery with over 18 years of experience.

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

☒ 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. Patient was injured on XXXX. XXXX had some x-rays, was told nothing was XX. Pain is reported at XX/10. Pain is XX. Patient has XX restriction with work activities, recreational and leisure activities, XX activities. Current Meds: XXXX. **Exam:** There is XX to palpation of the greater XX of the XX and the XX edge of the XX. Both XX XX signs are XX. Active ROM reveals XX XX and pain with XX rotation and XX forward XX. Strength test reveals XX XX of XX and XX XX. Lift off and XX press are XX. XX up test is XX. XX XX and XX motor and sensory examinations are XX. XX XX and XX pulses are XX. Imaging: I reviewed XXXX recent MRI dated XXXX which shows a clearly XX XX XX with XX almost to the level XX. Impression: XX XX tear. **Plan:** I advised XX XX and repair to improve function and reduce pain.

XXXX: Operative Report by XXXX. Post-operative diagnosis: 1. XX XX XX, XX XX. 2. Chronic long XX XX XX XX, XX XX. Operation: XX XX XX and XX XX XX repair.

XXXX: Office Visit by XXXX. We discussed starting a work conditioning program for XX weeks, for which the case manager will get approved.

XXXX: Office Visit by XXXX. **Subjective:** XXXX does not feel that XXXX XX is improving.

XXXX continues to report XX XX pain and XX. **Exam:** Active forward elevation is about XX°. Active internal rotation is to about the XX XX process. There is XX weakness of XX XX and mild XX of active XX XX.

XXXX: MRI XX XX interpreted by XXXX. **Impression:** 1. No significant XX XX XX. There are normal XX changes of the XX XX. 2. XX of the XX and XX XX XX without XX XX. 3. XX. 4. XX recess XX. 5. XX outlet related XX with a XX distance measuring XX but with an intact appearance of the XX muscle and XX.

XXXX: Office Visit by XXXX. Patient presents for results of MRI. **Plan:** 1. XXXX would likely benefit from a XX XX program. 2. I also prescribed XXXX. 3. Follow-up in XX months.

XXXX: Designated Doctor Evaluation by XXXX. Not at XX, Expected XX date XXXX. Rationale: The examinee continues with functional XX due to XXXX injury including XX and XX motion, however the XXXX MRI shows no evidence of a XX XX. XXXX is improving, however this a XX recovery due to XXXX XX and underlying XX. XXXX has been recommended for XX XX therapy and XX XX. Further improvement of XXXX condition is anticipated with this treatment.

XXXX: MRI of the XX XX without contrast interpreted by XXXX. **Impression:** 1. XX and XX XX repair without recurrent XX. Similar appearance of mild XX XX bulk XX without XX XX. 2. Chronic XX XX of the XX XX XX with interval development of XX XX XX loss. 3. Mild to moderate XX XX. 4. Moderate XX.

XXXX: Office Visit by XXXX. Plan to proceed with a XX XX program.

XXXX: Functional Capacity Evaluation by XXXX. Recommendation: At this time, XXXX is XX to perform the essential aspects of XXXX job. XXXX. XXXX demonstrated a max lift/carry up to XX pounds. XXXX demonstrated XX ability to perform the non-material handling aspects of XX/XX and XX XX. XXXX demonstrated XX tolerance to XX, XX, XX, XX, XX, and prolonged XX/XX. XXXX demonstrated fair XX. Recommend XXXX participate in daily, XX hour XX XX program in order to facilitate a safe and timely return to work without restrictions.

XXXX: Prescreen Evaluation and Recommendations XX XX/Work Conditioning Program by XXXX. It is recommended that XXXX attend the XX XX program to benefit from the comprehensive multi-disciplinary approach. The reported current level of functioning, reported XX, XX and XX behaviors, and XX quality of XX make XX a great candidate for the XX XX program.

XXXX: UR performed by XXXX. **Rationale for Denial:** In this case, the patient clearly has functional XX in the XX that prohibit from doing the XX work. The patient clearly needs more rehab. However, there is no XX XX of a XX which requires that which the XX program would provide. Rather, the patient seems to be a more appropriate candidate for a XX program. Therefore, the request for XX XX Program, daily for XX weeks (XX sessions) XX hours, as an outpatient for the diagnosis of complete XX XX XX of XX XX is not medically necessary.

XXXX: UR performed by XXXX. **Rationale for Denial:** XX. In this case, the patient did have a functional capacity evaluation and multidisciplinary evaluation, indicating that there were XX XX noted. However, the request was previously denied as there were XX significant XX findings that would be addressed by a XX program. Upon review of the available documentation, there was still no description of significant XX issues or XX XX/XX to be addressed with XX treatment. The screening indicated that XX patient had very XX XX, and a XX score of 0. As such, reconsideration request for XX XX program, daily for XX weeks (XX sessions) XX hours as outpatient for the submitted diagnosis of complete XX XX XX of the XX XX remains not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for a daily XX XX program x XX weeks is not medically necessary and should be denied.

This patient underwent a XX XX XX XX repair in **XXXX**, following a work injury. XXXX continues to have documented XX XX. XXXX recent XX MRI studies (**XXXX**) demonstrated an intact XX XX repair. A **XXXX** functional capacity evaluation (XX) concluded that XXXX would benefit from a XX XX program to facilitate a safe return to full duty work status. According to the pre-screening evaluation, the patient was noted to have XX XX and XX XX.

The Official Disability Guidelines (ODG) XX

This patient has functional deficits following XXXX XX XX repair. XXXX does not have significant XX XX issues, which would limit XXXX ability to return to full duty. XXXX does not require a multi-disciplinary approach of XX XX. Work XX would be more appropriate for him.
XX

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**
- ☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**