AccuReview

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[Date notice sent to all parties]: November 19, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX Hours of XX XX Program between XXXX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Physical Medicine and Rehabilitation Physician with over 15 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: Office Note dictated by XXXX: XX XX and XX XX XX pain, XX/10. The does increase with daily living activities. XX aggravate XXXX condition. XXXX continues to have XX with pressure or hitting XXXX XX. Medication management, mild heat, rest, and prior rest of XXXX orthopedic, is helpful. PE: no changes. Clinical Impression: XX XX traumatic XX starting with XX XX to the XX XX at the XX; Secondary diagnosis of XX XX of the XX XX XX. Treatment Plan: Follow up in XX months, maintain no work status for XX months, continue medication management per XX, authorization of the customized XX XX for the XX XX which is moving forward.

XXXX: Office Note dictated by XXXX: XX XX extremity pain XX/10. XXXX has pain in the XX that XX down into the XX and XXXX has pain and XX of the XX itself, involving all the XX and the XX. XXXX has an XX of the XX through XX XX of the XX XX. XXXX has difficulty XX at XX because of the pain. XXXX stated that the pain has varied over the last XX days from XX-XX/10. XXXX XX have been anywhere from XX/10 with an average of XX/10, with 10 not being able to do anything. Impression: XX consistent with a XX pain of the XX XX and XX XX. Plan: XXXX. Return to the clinic in XX months.

XXXX: Office Note dictated by XXXX: XX XX and XX XX XX pain between XX/10.

Change in weather to cold has increased pain and discomfort as well as activity of daily living. XXXX noted that XXXX continues to have XX to pressure or if XXXX hits XXXX XX. Medication management, mild heat, rest have been helpful for XXXX. PE: continued point tenderness of the XX but mostly of the XX sites of the XX XX through the XX XX. The claimant continues to have alteration of sensation that extends into the XX both XX and XX. Reflexes for the XX extremities are maintained at +XX/+4. Impression: XX XX XX XX starting with XX XX XX, secondary diagnosis of XX XX to the XX XX XX. Plan: Follow up in XX days, maintain no work status throughout this timer period, continue with XXXX due to XXXX ongoing XX XX, continue medication management per XXXX, and approval for XX for the XX XX but the provider will not distribute the XX until XXXX has been XX by the carrier. The XX will help reduce XXXX overall pain level and give the XX.

XXXX: Functional Capacity Evaluation dictated by XXXX. Recommendations: The claimant is currently overall functioning in the sedentary category work. After XXXX work-related incident, XXXX no longer has the use of XXXX XX XX, as XXXX has XX XX of the XX XX, according to the dictionary of Occupational Titles, US Dept of Labor, XX. XX

XXXX: Treatment Progress Report dictated by XXXX XXXX of unspecified XX, initial encounter. Treatment Plan: Outpatient Functional Restoration Program: emphasize the importance of function over the elimination of pain. Direct incorporated components of exercise progression with disability management and XX intervention will be addressed.

XXXX: UR performed by XXXX. Reason for denial: The documentation noted that the claimant has XX. The claimant is currently at sedentary PDL and the claimant's job XX is medium. XX; however, after XX successive calls over XX consecutive days it was not identified if there are any further treatment plan, if negative predictors of success have been identified if there are any further treatment plan, if negative predictors of success have been identified and how they will be addressed, and if there has been a clearance for any drug or XX to participation in this program. Therefore, medical necessity has not been established for XX hours of XX program.

XXXX: Response to Denial Letter dictated by XXXX. Requested a XX Program XX x a week for XX Hours on XXXX, which was denied. The documentation provided noted that the patient has functional deficits and is currently at a sedentary XX with a job requiring a medium XX. XX; however, after XX successive calls over XX consecutive days it was not identified if there are any further treatment plan , if negative predictors of success have ben identified and how they will be addressed, and if there has been a clearance for any drug or XX to participation in this program. Therefore, medical necessity has not been established. XXXX. XXXX surgical options were discussed yet XXXX reported feeling very overwhelmed with the decision making and opted out of all recommendations and asked to go home after XXXX rehabilitation was completed. The XX, subsequent to XXXX XX. XX This program will emphasize the importance of function over the elimination of pain. The request of XX weeks meets the ODG regarding evidence of demonstrated progress prior to further requested treatment. The use of objective and subjective scoring will also be implemented to chart response to treatment intervention.

XXXX: UR performed by XXXX. Recommended prospective request for XX hours of functional restoration program between XXXX be certified; XX days.

XXXX: Office Visit dictated by XXXX: unchanged. Impression: XX XX and XX of the XX XX with XX. XXXX is working with an XX XX to the XX XX. Plan: Continue XXXX.

XXXX: XX Evaluation dictated by XXXX. Recommendations: The claimant currently tested in the light category of work. After XXXX work-related incident, XXXX no longer has the use of XXXX XX XX, as XXXX has XX XX of the XX XX, according to the XX, XX. Our recommendation for this claimant would be to continue XXXX XX-XX treatment protocol as suggested by ODG guidelines, our objective will be to improve XXXX body mechanics, increasing overall endurance, strength, ROM and decrease pain and pain medication. XXXX will benefit from an additional XX days of the XX XX program. The XX XX program will continue to help to decrease of pain, pain medication and increase awareness of XX skills. XX.

XXXX: Office Visit dictated by XXXX. XX extremity pain XX/10, returns for evaluation of the XX of the XX XX. Impression: XX and XX XX from the XX, XX, XX, and XX rays of the XX XX. Plan: continue XX, which appears to be markedly improved. Refill prescriptions and continue all medications.

XXXX: Treatment Progress Report dictated by XXXX. Impression: XXXX of unspecified XX, initial encounter. Treatment Plan: Outpatient XX Program: Emphasize the importance of function over the elimination of pain. Direct incorporated components of exercise progression with disability management and XX will be addressed. Treatment Modalities for the claimant to include interventions to achieve Primary Goals of : Continue to assist in improving functional restoration by reduction on the Pain Experience Scale by XX points, reduction of the XX Pain Questionnaire by XX points, reduction of both subscales of the XX-R by XX points, reduce XX, and reduction of pain level by XX points; reduce and develop an appropriate XX reduction plan; XX

XXXX: UR performed by XXXX. Recommend prospective request for XX hours of functional restoration program between XXXX to be certified, XX days.

XXXX: Office Visit dictated by XXXX: XX XX and XX XX XX with pain XX-XX/10 and continues to have general difficulties noted with XXXX daily living activities. XX does cause XXXX pain and discomfort. XXXX has been a XX which XXXX notes is uncomfortable and does cause XXXX pain and discomfort. PE: There continues to be alteration of sensation that extends into the XX and XX XX. Reflexes for the XX XX are maintained at +XX/+4. Impression: XX XX XX XX XX at the XX XX XX to the XX XX at the XX; secondary diagnosis of sympathetic XX of the XX XX XX. Plan: follow up in XX weeks, maintain no work status throughout this time period, continue with XXXX functional restoration program, continue medication management, and referred to XXXX.

XXXX: Physical Performance Evaluation dictated by XXXX. Recommendations: The claimant continues to test in the light category of work. After XXXX related incident, XXXX no longer has the use of XXXX XX XX, as XXXX has XX XX of the XX XX. Our

recommendation for this patient would be to continue XXXX XX-XX treatment protocol as suggested by motion and decrease pain and pain medication. Claimant will benefit from an additional XX days of the functional restoration program. The functional restoration program will continue to help to decrease of pain, pain medication and increase awareness of XX. XX

XXXX: UR performed by XXXX. Reason for denial: The clinical information does not establish the medical necessity of this request. The ODG supports the use of chronic pain management programs for individuals with persistent pain complaints and supports up to XX hours. If treatment beyond XX hours is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. Additionally, individualized care plans explaining why improvements in functional capacity and XX with an initial XX hours of a chronic pain management program, but there has been an increase in XX still remain. Specific treatment recommendations included indicate ongoing therapy to XX. There is no indication that this cannot be done on an outpatient basis separate from the chronic pain management program. Based on the information available, the requested additional XX hours of the chronic pain management program would be considered not medically necessary as XX. As such, the request for XX Hours of Functional restoration Program is not medically necessary.

XXXX: Response to Denial Letter dictated by XXXX. The claimant's history of functional tests completed has shown displayed physical improvements. It is stressed that XXXX is XX XX (XXXX injury involved XXXX XX XX). XXXX is currently at light PDL and job requires medium PDL. XXXX floor level lifting with the XX XX only capacity was XX, limited secondary to pain. XXXX XX level lifting with the XX-XX capacity was XX, limited secondary to pain. XXXX overhead level XX XX lifting capacity was XX lbs, limited secondary to pain. XXXX is unable to push or pull any force of weight for any amount of length, limited use of XXXX XX XX secondary to pain. XXXX was able to walk, sit and stand for more than XX minutes with XX limitations. XXXX preformed a XX XX test with moderate limitations. It is being recommended XXXX proceed with an additional XX days of functional restoration program. Based on the above information this treatment team continues to recommend an additional XX secondary to continued functional limitations, XX, and case management needs (related to XXXX XX). The request of XX weeks meets the ODG regarding evidence of demonstrated progress prior to further requested treatment. Requesting an appeal.

XXXX: UR performed by XXXX. Reason for denial: The injured worker has a history of a XXXX to the XX necessitating XX XX. It was noted that the injured worker has completed XX days of functional restoration program but continued with very limited activities of the affected XX XX. Reportedly, the overall program had helped XXXX learn how to cope better with XXXX pain condition and had learned of a new form of pace. The ODG supports the use of chronic pain management programs for individuals with persistent pain complaints and supports up to XX hours. If treatment beyond XX hours is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. It remains relevant that the injured worker has completed a full course of a functional restoration program and remains with XX. The injured worker is already noted to have acquired the appropriate coping skills and pacing instruction such that further enrollment in a functional restoration program would not provide any additional benefit at this time. XX. Therefore, the request for XX Hours of Functional Restoration Program is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Denial of an additional XX hours of Functional Restoration Program is UPHELD/AGREED WITH since the request exceeds ODG recommendations and time frame for implementation, and clinically after completion of XX sessions/XX hours of a multidisciplinary functional restoration program over XX months there is plateau in function at LIGHT capability limited by high levels of pain, no documentation of reduction in medication use, XX. Therefore, after reviewing the medical records and documentation provided, medical necessity is not established for the request, resulting in the request for XX Hours of Functional Restoration Program between XXXX non-certified.
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)**