MEDRX

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DATE OF REVIEW: February 3, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient medical rehabilitation program, XX hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in chiropractic.

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

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of: Outpatient medical rehabilitation program, XX hours.

PATIENT CLINICAL HISTORY [SUMMARY]:
The IW (injured worker) was XX when XX XX a XX XX causing XX to XX, XX, and XX, XX XX, XX, XX XX extremity, and mid XX XX. There was an apparent XX. XX has had diagnostic imaging of the XX, XX XX, and XX with no remarkable findings. A XX evaluation was performed by XX in XX of XX. XX diagnosed the IW with a mild XX XX, XX, and XX secondary to mild XX injury. A XX resection was performed in XX. In XX of XX, XX opined that a treatment plan consisting of XX referral, orthopedic referral, pain management referral, and medications per the note. The FCE in XX indicates that IW can perform in the medium XX with XX pounds both occasionally and frequently. The XX report by XX indicated that the requested OMR (outpatient medical rehab) was not medically necessary secondary to the IW performing the duties of XX work currently without significant functional deficit. The job description listed is that of a XX and XX employer is XX.
Per the documentation, XX job duties (demands) include XX, XX, XX, XX (XX), and XX. The IW also wrote other duties as: XX, XX, XX, and XX, XX, and XX. The XX FCE indicates XX can XX. Dynamic XX XX. with only a XX without an increase in pain scale. Functional lifts (XX lbs.) from XX to XX showed a slight increase in pain scale (6-7) and BPM while XX lifting (XX lbs.) revealed pain that

radiates from the XX XX to the to the XX of XX XX and XX (non-anatomical) and an increase in XX. Pegboard tasks were within normal limits. Function specific testing noted XX with basically all movements. Dynamic XX indicated an ability to carry XX lbs. in all phases. All measured ROM phases were reduced severely with the exception of the XX XX which was moderately reduced. XX was approximately equal XX. XX opines that the XX for XX injury is necessary to allow "an increase in functional tolerances for a safe and successful return to work."

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

Outpatient medical rehabilitation program, XX hours, is not medically necessary.
After reviewing the ODG XX section, the following are the criteria mentioned to determine medical necessity of the requested procedure:

XX

After reviewing all the criteria mentioned by the ODG, it is apparent that the requested OMR program is recommended for moderate to severe XX injuries. The IOM recommends XX therapies for TBI prior to this type of program; however, the IW has not had any XX rehabilitation at this point per the records provided. The ODG also indicates that if treatment duration in excess of XX months is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. This criterion is not met as per the statement by XX when they stated that this was to help XX return to work safely yet the FCE clearly indicates that XX is able to do so per the job demands provided. Lastly, ODG requires that the program be overseen by "a physician, board-certified in XX or another specialty, such as XX or XX, with additional training in XX injury rehabilitation." The program manager listed on the XX OMR Interdisciplinary Plan and Goals of Treatment request is XX who has not provided documentation of additional training in XX injury rehabilitation. Based upon these findings, the request is not medically necessary.

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)**