Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)

DATE OF REVIEW: FEBRUARY 19, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Chronic Pain Functional Restoration X XX hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full-time practice of medicine.

REVIEW OUTCOME

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

☐ Upheld (Agree)

XX Overturned (Disagree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX-year-old XX who was injured on XX, in a XX when a XX XX. The claimant was diagnosed with a XX of the XX and XX XX, XX of XX, and XX of the XX. A CT scan on XX, documented XX XX, acute XX of the XX XX, hard XX, and XX. There were remote fractures of the XX XX floor and XX XX XX. On XX, XX surgery was performed on the XX XX XX. Medications included XX with XX, XX, and XX. Treatment included XX hours of XX therapy, XX status examination, and XX assessment of XX hours in XX. An evaluation on XX, documented a 36 on FAB Q work and 20 on PA. The XX Inventory was 33 and XX Inventory was 18. The ODI score was 44% and Pain Score was 6. The current physical demand level was a light/medium PDL and return to work job was heavy PDL.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The previous non-certification on XX, was due to lack of documentation of failure of lower levels of care with absence of other options. Additional records were not submitted for review. The

claimant has undergone previous lower levels of care including diagnostic testing, XX therapy, medications, restricted work status, XX surgery, and XX assessment. There was documentation of XX current PDL that did not meet XX prior job duties. There was documentation of impaired XX status with elevated XX and XX levels, as well as elevated disability and fear avoidance levels. There was no documentation of a primary XX XX, and XX XX condition did have physical components. The claimant is not a candidate for lower levels of care such as a XX conditioning program, and has exhausted lower levels of care. This request is within ODG guidelines for a trial of XX visits (XX hours), and then a re-evaluation should take place to assess for progress and appropriateness. Total treatment duration should generally not exceed XX weeks (XX full days or XX hours). The request for XX hours of a functional restoration program is medically necessary and certified.

REFERENCE:
Official Disability Guidelines Pain XX

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES