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DATE: 1/24/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Initial XX days Interdisciplinary Pain Rehab Program, XX hours per day, XX per week Total of XX hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer specializes in Physical Medicine and Rehabilitation with over 25 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]:
Claimant is a XX-year-old XX that sustained a work injury on XX, when XX XX. The compensable injury id for XX XX and XX XX.

XX: Progress Note by XX. Pt reports XX XX. When XX XX, XX XX were XX and XX to XX XX and XX pain. Denies prior XX problems. Pain radiates to the XX XX. On Examination: XX XX- XX are felt XX, XX XX pain palpable and tender XX XX. ROM- XX is XX, XX is 0 with severe pain and guarding. XX is positive on the XX to the XX. XX XX: palpable tenderness to the XX XX, tender XX on XX. XX is XX/5, XX is XX/5, XX is XX/5, XX is XX/5, internal rotation is XX/5, rotation is XX/5. ROM XX is XX, XX is XX, internal rotation is XX, external rotation is XX. XX is positive, XX test is positive, XX XX is positive to the XX XX joint. Assessment- XX XX pain, XX XX pain, XX strain, and Strain of muscle , XX and XX of XX XX. XX XX XX injection. Inject XX. Start XX XX, XX XX XX XX.

XX: MRI XX XX. Impression- XX-XX XX XX measuring XXmm with impingement of the XX XX XX XX. XX-XX XX posterior XX XX measuring XX mm.

XX: Physical therapy Session XX, XX. Pain is XX/10. XX X: Pain radiated to XX XX. Difficulties with daily living bending, sitting kneeling, squatting, pulling, pushing, lifting. Pain location is XX. Relieving factors include rest, heating pad. XX are present XX, XX XX pain palpable and tender XX XX. XX XX is XX/5 XX, XX XX is XX/5 XX. XX is limited, extension is limited. XX/XX: Pain XX/10. Difficulties with daily living bending, sitting, lifting, pushing, squatting, walking. Rest, ice, reliving factors. XX XX: tenderness to XX XX, tender XX. XX is restricted, internal rotation is restricted, external rotation is restricted.

XX: LESI, XX

XX: MMI/Impairment Rating by XX . Claimant has not reached MMI. ODG recommends XXPT visits over XX weeks for XX sprain/strain and for an XX XX disorder. In addition, ODG recommends XX visits over XX weeks for XX strain/sprain. XX underwent XX PT visits between XX and XX. XX underwent XX XX visits between XX and XX. XX injuries can no longer be reasonably anticipated. At this time, conservative treatment has failed. It would be appropriate to see if XX is a surgical candidate. XX has not reached XX MMI. Anticipated date is XX.

XX: XX XX XX

XX: XX XX at XX-XX and XX-XX

XX: Physical Therapy Session with XX. Session #XX for post- surgical XX XX pain. Pain is XX/10. Radiation down XX XX. Difficulty with daily activities living, sleeping, bending, sitting, squatting, pushing, pulling, lifting and steps. Pain is XX. Relieving factors are rest and ice pack. Examination: healed surgical scar. XX XX pain palpable, XX is present to the XX and tender at the XX XX XX side. XX reflexes are equal and brisk. XX, extension, XX XX XX and XX XX XX is limited. Tenderness to XX XX XX, tender XX and XX.

XX: FCE, XX. Pt was observed to exhibit poor body mechanics. XX was unable to reach the floor to complete the knuckle-floor dynamic lift. XX was capable of carrying XX lbs and was unable to complete the XX lift. XX reports significant pain levels and XX sided XX with non-material handling and repetitive motion testing. Based on todays results it is this evaluators opinion that XX cannot RTW safely at the required PDC. Considering th severity of XX complaints and XX post-operative status, XX may benefit from a chronic pain program and is unlikely to respond to a structured RTW program. XX job demand level is medium, XX current level is unclassified. XX XX XX Score- XX out of 63. XX XX Score- XX out of 63.

XX: Progress Note by XX. XX was approved for XX post -surgical PT sessions and reports XX/10 XX pain. The XX XX has decreased some but the numbness and XX and occasional pain to the XX XX. XX wears the XX and has been doing XX XX. XX had a XX done that was normal. Previous FCE shows XX has not reached XX PDC. XX has completed the chronic pain program with functional pain center. XX has been seeing XX and had completed pain management PRIOR TO THE SURGERY. XX was seen by XX XX and the surgery was performed XX. XX has attended XX POST OPERATIVE THERAPY SESSIONS. XX is not working. XX takes XX XXmg, XX. XX takes XX XX only PRN. XX was seen by XX XX and released on light duty. Recent FCE shows XX has not met the required PDC. XX XX- XX noticed XX, XX XX pain palpable. XX XX is XX/5 XX, XX XX is XX/5 XX. ROM is XX, extension is XX, XX XX XX is XX and XX XX XX is XX. Orthopedic Maneuvers XX is positive on the XX to the XX, braggards is positive on the XX. XX XX tenderness to the XX, tender XX and XX with a click. Difficulty sleeping due to the pain. Start XX XXmg. Continue HEP. Considering poor surgical outcome and persistent XX pain, I will order MRI with contrast to rule out repeat XX. XX does not appear to be a good candidate for a RTW program due to level of XX clinical symptoms, so if MRI is not remarkable, XX may be a good candidate for a chronic pain program. XX XX is improved from XX HEP.

XX: Request for Chronic Pain Program, XX. Physical Exam: XX: Loss ROM- XX.9%. XX: XX/60. XX: XX/25. XX-Rotation: XX/30. XX-Rotation: XX/30. XX-XX Flex: XX/30. XX-XX Flex: XX/30. XX was seen today. ROM: XX XX.1%. XX is determined to be slow. Motor Strength Testing of the XX and XX extremities demonstrated weakness of XX XX-XX of XX. Orthopedic testing revealed a positive XX on the XX at XX degrees. XX XX/10. XX XX pain down to XX with numbness. XX of XX XX and XX XX. Pt feels increased XX and XX XX pain with sleep, prolonged walking and standing. Tenderness to XX-XX. Motor sensory and reflexes deficiencies of XX XX when compared to XX. Pt would benefit from a Chronic Pain Program. XX: date XX, XX, required PDC: Medium Current PDC: Unclassified.

XX: UR by XX. Rationale- according to ODG, neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A CPP should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated. Cannot be approved, as this client has already had this type of program in the past for this exact same injury and exact same body part, XX-XX.

XX: UR by XX. Rationale- This request was previously denied. No additional medical records were submitted for review. Prior non-certification is supported. Guidelines do not support reenrollment or repetition of the same or similar rehabilitation program for the same injury or condition. The claimant has already attended XX hours of CPM, without objective documentation supporting increased function or decreased pain scores. Based on medical documentation submitted, not supported. Peer-to-peer call on behalf of XX was unable to provide additional information that might allow certification.

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

The previous adverse decisions are Upheld. The requests exceeds ODG recommendations given completion of previous XX hours of a chronic pain program without documented subjective or objective functional improvement and subsequent XX surgery. At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. There has been completion of post operative physical therapy for the XX XX with documentation of medication as needed, performance of a home exercise program and release to light duty. Therefore, the request for XX sessions/XX hours of a Chronic Pain Management Program is considered 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)**