AccuReview

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

XX: Follow up dictated by XX XX, MD
XX: Evaluate & Treat at Injury 1 of XX dictated by XX XX, MD
XX: Functional Restoration Program at Injury 1 of XX dictated by patient
XX : Assessment/Evaluation for Functional Restoration Program at Injury 1 of XX dictated by XX. LPC
XX : Functional Capacity Evaluation at Injury 1 of XX dictated by XX, DC
XX: Reconsideration: Functional Restoration Program Preauthorization Request at Injury 1 of XX dictated by unknown
XX: Request for Reconsideration Alternate Reviewer Request at Injury 1 of XX dictated by XX XX, MD
XX: Physical Performance Evaluation at Injury 1 of XX dictated by XX, DC
XX : Request for Reconsideration at Injury 1 of XX dictated by unknown
XX : IRO Decision at XX Management Organization, Inc. dictated by XX
XX : Reassessment for XX Pain Management Program Continuation at Injury 1 of XX dictated by XX, PsyD LPC
XX : Physical Performance Evaluation at Injury 1 of XX dictated by XX, DC
XX: Continuation Functional Restoration Program Preauthorization Request at Injury 1 of XX dictated by XX, DC
XX : Request for Additional XX Pain/Functional Restoration Program (outpatient) at Injury 1 of XX dictated by XX, DC
XX: UR performed by XX, DO
: Reconsideration: Continuation Functional Restoration Program Preauthorization Request at Injury 1 of XX dictated by XX, DC
XX : Preauthorization at Injury 1 of XX dictated by XX, DC
XX: UR performed by XX, MD

PATIENT CLINICAL HISTORY [SUMMARY]:

XX: Follow up dictated by XX XX, MD. CC: XX pain XX down XX with XX and XX. This is indicative of the XX for which MRI is recommended. XX has XX as well, has a XX, and XX is very low. XX also complains of XX pain. Current medications: XX, XX, XXXX. XX XX is very slow and XX XX both XX and X. XX does have a notable XX XX level, XX is very painful and limited with XX test. XX tenderness, XX noted with XX. Impression: XX trauma, XX trauma, post-XX syndrome, XX , XX strain. Plan: extensive injury examination, workup for XX functional program. XX intake, XX l performance examination, XX with restrictions and follow up in one month.

XX : Assessment/Evaluation for Functional Restoration Program dictated by XX . LPC. Clinical Summary: Claimant endorsed having one or more XX symptoms that are XX and result in significant XX of XX life. In addition, there were indications of excessive XX, XX, or XX related to the XX symptom or associated health concerns as manifested by XX having disproportionate and persistent thoughts about the seriousness of XX symptoms with excessive time and energy devoted to these symptoms or health concerns. This state has existed for more than 6 months and is hindered predominantly by pain. XX Injury: XX, XX, XX, XX, XX. Treatment/Plan: Claimant would benefit from XX restoration program after exhausting conservative treatment including XX. Currently, XX is negatively impacted by pain and reduced functioning across activities of daily living. XX has responded positively to past treatment and failed to restore XX functioning. XX will require interdisciplinary functional restoration program in order to reduce XX pain and fear avoidance behaviors while improving XX physical capabilities and functioning in order to propel this claimant toward a safe return to work and facilitate medical case closure.

XX: Functional Capacity Evaluation at Injury dictated by XX, DC. Assessment: The claimant has made objective improvements in the following area since last evaluation: XX endurance, XX, XX, XX, XX specific testing, XX, XX,

decrease in medication. XX demonstrated functional deficits and would benefit from additional medical; XX was unable to complete parts of the test due to increases in acute pain levels and spasms on attempted performance tests, severely limited functionally. The claimant cannot safely perform XX job demands based on comparative analysis between XX required job demands and XX current evaluation outcomes. Recommendations: Any referrals the treating doctor deems necessary. XX would benefit from participating in an active XX rehab or XX therapy program. This program may be necessary in order to improve the claimant's condition and get the areas of injury more stable as to avoid further injury, or re-injury to the areas. Recommend XX evaluation for emotional complications, XX indicates the claimant cannot safely perform XX XX full time/full duty job demand XX of light to medium. Based on the claimant's current XX. XX would benefit from a XX to further strengthen and improve XX as well as improving pain coping mechanisms.

XX : XX Performance Evaluation dictated by XX , DC. Assessment: Claimant was unable to complete part of the test due to increases in XX levels and XX on attempted performance of tests, severely limited functionally. XX cannot safely perform XX job demands based on comparative analysis between their required job demands and XX current evaluation outcomes. XX has shown modest improvement with XX. Recommendations: XX secondary to pain, XX function, and XX. XX indicated XX cannot safely perform XX XX XX lbs. Patient current XX. Claimant needs to follow up with primary care physician for XX XX.

XX : Reassessment for XX Program Continuation dictated by XX , XX LPC. Clinical Summary: XX and XX emotional XX with XX interest in previously XX. Currently only sleeping X hours per night and feeling XX upon awakening. XX also endorsed XX and a XX with XX or XX with difficulty XX. These feelings of major XX with recurrent episodes were severe with moderate accompanying XX. Compensable Injury: XX, XX, XX, XX, XX contusion. Treatment/Recommendations: Agree with recommendation for claimant to participate in XX management program as XX has exhausted conservative treatment yet continues to struggle with pain and XX problems that pose difficulty to XX performance of routine demands of living and functioning. Thus, it is recommended that the claimant be approved for continued participation in the XX management program in order to further increase XX physical and functional tolerances and to facilitate a safe and successful return to work.

XX : Physical Performance Evaluation dictated by XX , DC. Assessment: The claimant has made objective improvements in the following areas since last evaluation: XX XX, XX lifting, and functional specific testing. Overall modest improvement is likely due to deconditioning as a result of XX months of XX while waiting for insurance approval. XX was unable to complete parts of this test due to XX XX pain that is not part of XX compensable diagnoses. The claimant cannot safely perform XX job demands based on comparative analysis between XX required job demands and XX current evaluation outcomes. Recommendations: XX evaluation for the claimant's XX as a result of this injury and the surrounding problems with being off work or work restrictions which includes but is not limited to the possibility of XX XX of function, and delayed recovery. Current XX and would benefit from continuation of XX pain management for further strengthen and improve functional capabilities as well as improving pain coping mechanisms.

XX : UR performed by XX , DO. Reason for denial: This is a case of a XX -year-old XX who sustained an injury on XX when a XX was up in the XX. XX was looking down and taking apart something on the XX when all of a sudden, the XX XX and hit XX in the XX. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request in non-certified. Clarification is needed as there were inconsistencies documented on the reviewed medical records submitted for review. Per XX dated XX, there was documentation that the claimant cannot safely perform their XX to Medium and that based upon today's XX the claimant's current XX. While, the recent XX documented that the claimant cannot safely perform their XX full time/full duty job demand XX. Based upon today's XX, the claimant's current XX. In addition, based on the claimant's XX deficits, there were limited improvements noted as the claimant's BAI score was increased from XX to XX and BDI-II score was increased from XX to XX.

xx: Reconsideration: Continuation XX Program Preauthorization Request dictated by XX, DC. Prior treatment modalities had failed to stabilize the claimant's XX XX, increase XX engagement in activities of daily living, or enhance XX physical functioning such that XX could safely return to work. XX had developed a XX pain syndrome; the treatment of choice is participation in an XX pain rehabilitation program. Based on progress made within XX day trial, the treating

physician has prescribed participation in an XX chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce the claimant's pain experience, develop self-regulation skills, and facilitate a timely return to the work force. Thus, additional XX hours in a XX restoration program appears reasonable and medically necessary for any last management of the claimant's pain symptoms and related XX problems, as it is recommended treatment of choice for patients with XX pain syndrome.

XX: UR performed by XX, MD. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. This calamint had injury to the XX including XX injury. XX could trial an XX due to light to medium XX with a job of heavy XX. XX initial XX days of the rehabilitation program maintains XX limited ability to lift no more than XX pounds occasionally, but XX can also lift XX pounds frequently. This similarity between occasional and frequent lifting tests suggests a lack of effort as XX pounds frequent translates to heavy XX while XX pounds occasionally only translates to a XX XX L or XX to XX as originally tested. This disparity should alert to possible lack of effort on the initial and follow up lifting tests. Nevertheless after 2 weeks of XX l and XX the patient objective examination findings do not support significant gain to justify extension of this multidisciplinary program in agreement with the prior denial, the request is non-certified.

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

Based on the records submitted and peer-reviewed guidelines, this request is non-certified. This claimant had injury to the XX including XX l injury. XX could trial an XX due to XX with a job of heavy XX. XX initial XX days of the rehabilitation program maintains XX limited ability to lift no more than XX pounds occasionally, but XX can also lift XX pounds frequently. This similarity between occasional and frequent lifting tests suggests a lack of effort as XX pounds frequent translates to heavy XX while XX pounds occasionally only translates to a XX as originally tested. This disparity should alert to possible lack of effort on the initial and follow up lifting tests. Nevertheless after 2 weeks of XX and XX rehab, the patient objective examination findings do not support significant gain to justify extension of this multidisciplinary program in agreement with the prior denial, the request is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for Continuation of XX Pain Management Program –XX hrs. XX is non-certified, denied.

Per ODG:

Criteria for the general use of multidisciplinary pain management programs:

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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)**