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INFORMATION PROVIDED TO THE IRO FOR REVIEW:
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PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX-year-old XXXX that was hurt at XXXX while exiting a XXXX XXXX, when XXXX XX a XX and XX. XXXX has a diagnosis of incomplete XXXX XXXX tear or rupture of the XXXX XXXX, not specified as traumatic.
XX: MRI of XXXX XXXX. Impression- 1. . 2.

XX: Office Visit Dr. XXXX. XXXX XXXX pain x's 2 months. Pain occurs when XX XXXX XXXX and with activity. XX, XX. Associated with difficulty XX, worse with XX, XX pain, instability, worse with XX, LROM, XX XX pain, worse with XX and XX. Pain 9/10. Inability to XXXX, difficulty lifting objects/weight, attending XX. XXXX XXXX tear, recommend surgery and XXXX therapy.

XX: XXXX Evaluation. XXXX reports R XXXX pain and stiffness s/p RCR. Has been trying to do exercise but has increased pain. XX handed. XXXX reports some XX - mainly entire XX. Pain now is 5. Pain at worst is 10. Functional Impairments-XX XX XX. XXXX goal is to be able to us XXXX again. Flex=32◦/70◦. Abd= 30◦/42◦. IR= R XX/30◦. ER ear/10◦. Significant XX with limited GH mobility. ER>ABD. Unable to use XXXX fonl'y (?handwritten)

XX: Office Visit with Dr. XXXX. XXXX seen today for s/p XXXX RTC repair follow up. Appropriate XXXX and strength, XXXX will continue to XXXX on strengthening, 6 week follow up.

XX: XXXX Note. 6/10. XXXX: Flex= 130◦/145◦. Abd=90◦/100◦. IR- L2. ER-behind head. MMT= Flex=3/5. Abd=3/5. IR-3/5. ER-3/5. XXXX continues mobility restrictions with poor GH of mobility. Aggressive XXXX/Ex/manual therapy but still lacking functional ?? of XXXX. Cont to progress XXXX strength and XXXX.

XX: XXXX Note. XXXX reports XXXX can reach XXXX XXX XXX. Still has significant difficulty with use of XX in FCNL capacity. Current pain is 4.5.. Worst is 8. Demonstrates improved active motion of XX XXXX. Still presents with UT compensation, but decreased with verbal and tactile cue GH JT stiffness, poor serratus anterior & RTC actwation leading to XXXX elevation instead of pure GH motion. XXXX able to perform increased AROM in decreased gravity position.

XX: Office Visit with Dr. XXXX. XXXX seen to day for s/p XXXX RTC repair follow up. XXXX improved with XXXX, but patient still needs more XXXX. 6 wk f/u

XX: Urgent Care Visit with XX, FNP. Moderate rt XXXX pain. Constant and stable. Pain radiate to the XXXX arm. Achiny/throbbing. Aggravated by lifting and movement. Associated symptoms include joint tenderness and swelling. XXXX states continued XXXX was denied.

XX: FCE. XXXX. XXXX is currently performing lifts and carries at a XXXX demand characteristic level of Light-Medium as XXXX was able to up to XX lbs today. XXXX continues to be limited by XXXX XXXX XXXX pain and lack of motion. XXXX does not appear to be capable of performing either the material-handling component of XXXX job or the non-material handling requirements of XXXX job at this time. XXXX has had extensive XXXX therapy and apparently plateaued in

XXXX recovery. XXXX would now benefit from the full body strengthening and XXXX as well as the job-specific XXXX-stimulation activities. XXXX. XXXX appears to be a good candidate for a full return to XXXX following the program.

XX: Prescreen Evaluation XXXX XXXX. Moderate pain level 5/10 currently, worst at 9/10 and best 3/10. Beck's XX Inventory- moderate XX, score of 18. Becks XX Inventory- XX XX, score of XX. FABQ-PA, score of 14/24. FABQ-W, score of 39/42. It is recommended that XXXX. XXXX attend the XXXX XXXX Program to benefit from comprehensive multi-disciplinary approach. The reported current level of functioning, XX, XX and XX behaviors, and reduced quality of life which makes XXXX a great candidate for the program.

XX: Office Visit, Dr. XXXX. RT XXXX- appropriate XXXX and strength, 4/5 RTC strength. Strength improving. XXXX XXXX.

XX: XXXX XXXX Program. Demonstrates good motivation and effort with all activities when present. XXXX demonstrated increased XXXX XXXX flexion, continued decreased XXXX noted overall. XXXX had mild improvements in lift/carry, and increased cardiovascular endurance was noted. Will continue to progress the program per XXXX's tolerance. It is recommended that XXXX continue the program 8 hours daily for 5 remaining sessions.

XX: XXXX XXXX Program. Demonstrated good motivation and effort with all activities when present. Improved lift/carry. XXXX has progressed from a light-medium XXXX demand capacity to a medium XXXX demand capacity. XXXX demonstrates improvements in XXXX. XXXX has progressed 32 degrees of flexion and 20 degrees abduction. At this time, as the patient is progressing well with the program. Recommend XXXX continue the program for an additional 10 sessions, 8 hours per day.

XX: UR by Dr. XXXX. Rationale- According to the ODG, patients must undergo reassessment after two weeks within the program with documentation provided evidence of patient compliance and improvement. The guidelines further indicate that outcome should reflect the goals initially proposed, including those specifically addressing deficits indentified during the screening procedure. The physician will need to provide evidence of the patient's XX XX scores had reduced as well as XXXX XX and XX related issues which were previously addressed in the XX screening prior to involvement in the program. The most recent document provided for review dated XX identified the patient has made substantial gains physically. However, there was no mention of any assessment conducted pertaining to the patients XX status. Therefore, not authorized unless this issue is addressed.

XX: Letter of Reconsideration, Dr. XXXX. XXXX. XXXX was obviously progressing in the XXXX XXXX Program. XXXX did not show any XX XX during treatment. XXXX demonstrated good participation in the XXXX psychological sessions. In both progress notes from the counselor, it was was shown that the patient was pleasant and attentive. XXXX participated in discussions.

XX: UR by Dr. XXXX. Rationale- Previous non-certification is supported. Additional records included an evaluation on XX. The claimant had functional improvement progressing toward return to preinjury XXXX demand. There is no objective documentation of decreased XX/XX scores, which were noted to have been a substantial limitation in recovery prior to start XXXX XXXX.

XX: Prescreen Evaluation XXXX XXXX. Current pain level of 10/10 in XXXX rt XXXX. Worst is 10/10 and best is 7/10. BDI Score is score of 22, moderate XX. Beck's XX Inventory is minimal XX with a score of 14. The XX-XX; XX XX is 16/24 and XX-W is 42/42. XXXX reports functioning at 20% of XXXX pre-injury levels.

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

The previous adverse decision is XX. After completion of 10 visits of XXXX XXXX, there is demonstration of minimal functional improvement from LIGHT-MEDIUM to MEDIUM capacity with NO documentation of required/goal XXXX level, NOR documentation of return to XXXX plans. Furthermore, there is documentation of INCREASE in all XX parameters including pain level from 5-9/10 to 7-10/10, Beck XX Index from 18 to 22, XX XX

Index from 6 to 14, XX XX XXXX Activity from 14/24 to 16/24 and XX XX XXXX from 39/42 to 42/42 with no discussion regarding explanation of the increases or plan to address. There is also question regarding any past and/or current use of analgesic medication or XX medications, and whether any medication use is addressed by this XXXX XXXX program. Therefore, the request for 80 hours XXXX XXXX program is considered not medically necessary.

Per ODG:

ODG Criteria

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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)**