Applied Assessments LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 5/10/2019 11:29:34 AM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: Texas Workers' Compensation XXXX Status Reports – XX

- Clinical Records – XX
- Function Capacity Evaluation – XX
- Physical Therapy Note – XX
- Appeal Determination Denial Letters – XX
- Adverse Determination Letter – XX
- Peer Review – XX
- Prospective IRO Review Response – XX
- Diagnostic Data – XX

PATIENT CLINICAL HISTORY [SUMMARY]: XXXX. XXXX is a XXXX-year-old XXXX with date of injury XXXX. While working, XXXX was injured as a result of specific XX and XXXX noted immediate XXXX XXXX pain. XXXX was diagnosed with XXXX XXXX pain. A Functional Capacity Evaluation (FCE) was completed by XXXX XXXX, OTR on XX. XXXX. XXXX completed a series of tests over the course of four hours and was noted to have given XXXX full effort and consistency. XXXX required physical demand level was XX XX (lifting up to greater than XXXX XXXX). XXXX was deemed able to perform medium level XXXX with occasionally lifting up to XXXX XXXX. XXXX did not meet XXXX reported maximum full duty job lifting requirements of greater than XXXX XXXX occasionally during the evaluation. XXXX was self-limiting with dynamic lifting due to complaints of XXXX XXXX discomfort. XXXX heart rate increased with minimal effort, which could be due to not only complaints of pain but severe deconditioning. XXXX active range of motion revealed flexion of XXXX XXXX, extension of XXXX XXXX, XXXX lateral flexion of XXXX XXXX, right lateral flexion of XXXX XXXX. XXXX straight leg raising was XXXX XXXX and right was XXXX XXXX. The deficits were noted in the body weight management, dynamic lifting / carrying intolerance, positional tolerances, cardiovascular fitness, and complaints of severe XXXX XXXX XXXX discomfort with dynamic activity XXXX. XXXX was seen by XXXX XXXX, MD on XX. XXXX. XXXX complained of XXXX-sided XXXX XXXX pain. XXXX had no radicular pain complaints. XXXX stated that the symptoms had been unimproved since the time of the injury, XXXX months prior. XXXX rated the pain at 6/10. XXXX chief complaint was related to XXXX-sided XXXX XXXX pain. XXXX was not taking any prescription medications for those symptoms. XXXX previous XXXX release was unchanged. Dr. XXXX was unable to predict when XXXX. XXXX might reach maximum medical improvement. XXXX prognosis was fair to good. An MRI of the XXXX XXXX dated XX demonstrated normal-appearing XX above the XXXX level. There was a question of small XX XX into the XXXX XX XX at the XXXX level. It might contact the exiting XXXX XXXX XXXX XXXX, but represented a borderline abnormality and was not well visualized on the scan due to technical factors. An electrodiagnostic examination report dated XX demonstrated normal EMG without convincing electrophysiologic evidence of XX XX or XX. There were normal peroneal and tibial motor XXXX conduction studies. There was no electrophysiologic evidence of generalized peripheral neuropathy. The treatment to date included physical therapy and medications (XXXX, XXXX, and XXXX). Per a utilization review dated XX, the request for XXXX XXXX program 30 hours for the XXXX XXXX with a functional capacity evaluation (FCE) was denied by XX XX DO. Rationale: "The Official Disability Guidelines (ODG) state that XXXX XXXX involves an additional series of intensive physical therapy (PT) sessions required beyond a normal course, primarily for supervised exercise training, and is contraindicated when there are significant XX, XX, or XX barriers to recovery that are not addressed by these programs. XXXX XXXX (WC) visits are typically more

intensive than regular PT visits, lasting two to three times longer and focusing on XXXX-required endurance. Consistent with all PT programs, WC participation does not preclude a patient from concurrently working. I would note that in this case, physical therapy reportedly did not benefit. Further, the claimant continues with high levels of symptoms that would interfere with XXXX XXXX noting that it is more intense than regular therapy. The Functional capacity evaluation noted self-limited action. XXXX XXXX is primarily indicated when symptoms are significantly resolved, and intensive exercise can then be undertaken to build the individual up. No recent physician visits were provided that would support the request. I would note that the Guidelines also state that the best way to get an injured worker XXXX to XXXX is with a modified duty return-to-XXXX (RTW) program (see the section "ODG Capabilities & Activity Modifications for Restricted XXXX" in XXXX), rather than a XXXX hardening/XXXX XXXX (WH/WC) program." Per a utilization review dated XX the request for XXXX XXXX, XXXX was denied by X XX, MD. Rationale: "According to the provided documentation, it was documented the patient had continued XXXX sided XXXX XXXX pain and the patient rated the pain at 6/10 on visual analog scale. There was evidence the patient has had prior physical therapy for the treatment of XX. A recommendation was made for a XXXX XXXX program for treatment of the XXXX XXXX for this patient. This request was previously denied as there was no evidence of improvement with prior therapy and the request was not consistent as additional physical therapy was recommended for this patient. The submitted documentation still did not provide any physical therapy notes documenting the necessity of a XXXX XXXX program for treatment to the XXXX XXXX for this patient. There was no clear evidence of an improvement in symptoms followed by a plateau and there was no official job description provided for this patient. A frequency and duration of treatment was not documented in this request. As such, the medical necessity of this request was not established for this patient." Per a peer review by XX , MD dated XX, the injury sustained was a XX of the XXXX region of the XXXX. There were no other ongoing medical diagnoses directly related to the reported mechanism of injury. The findings noted in the MRI were XX-related, ordinary disease of XX XX changes consistent in an individual of the particular body habitus. Given the body habitus of the individual, those degenerative changes with no specific objective clinical data suggesting they were a function of the reported mechanism of injury. Dr. XX suggested the only additional treatment was a home exercise protocol augmented with over-the-counter analgesic preparations.

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

Based on the clinical information provided, the request for XXXX XXXX program, XXXXXX: XXXX and XXXX hardening, first two hours XX : XXXX and XXXX hardening, each additional hour following the first two hours is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review dated XX, the request for XXXX XXXX program 30 hours for the XXXX XXXX with a functional capacity evaluation (FCE) was denied by XX DO. Rationale: "The Official Disability Guidelines (ODG) state that XXXX XXXX involves an additional series of intensive physical therapy (PT) sessions required beyond a normal course, primarily for supervised exercise training, and is contraindicated when there are significant psychosocial, drug, or attitudinal barriers to recovery that are not addressed by these programs. XXXX XXXX (WC) visits are typically more intensive than regular PT visits, lasting two to three times longer and focusing on XXXX-required endurance. Consistent with all PT programs, WC participation does not preclude a patient from concurrently working. I would note that in this case, physical therapy reportedly did not benefit. Further, the claimant continues with high levels of symptoms that would interfere with XXXX XXXX noting that it is more intense than regular therapy. The Functional capacity evaluation noted self-limited action. XXXX XXXX is primarily indicated when symptoms are significantly resolved, and intensive exercise can then be undertaken to build the individual up. No recent physician visits were provided that would support the request. I would note that the Guidelines also state that the best way to get an injured worker XXXX to XXXX is with a modified duty return-to-XXXX (RTW) program (see the section "ODG Capabilities & Activity Modifications for Restricted XXXX" in XXXX), rather than a XXXX hardening/XXXX XXXX (WH/WC) program." Per a utilization review dated XX the request for XXXX XXXX, XXXX was denied by XX, MD. Rationale: "According to the provided

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Given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence based guidelines and the decision is XX.

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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC XXXX XXXX PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Fitness for DutyWork XXXX, XXXX hardening