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An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX Therapy

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. Per an operative note dated XXXX underwent XXXX XX zone repair of XX% extensor XX XX (XX) tendon laceration, XXXX XX zone XX repair of XX% XX XX tendon laceration and XXXX XX zone XX repair of XX% XX XX XX laceration. A post-operative evaluation was completed by XXXX. XXXX presented for a follow-up of the surgery. The incisions were healing well with no sign of infection. XXXX had a good integrity of the XX XX repair. XXXX had a lot of XX of the XX as would be expected at the time with attempted flexion. A XX / XX XX was applied. XXXX recommended initiating formal therapy sessions to include passive extension, active flexion, placed on hold, and the extensor outrigger XX. XXXX was seen by XXXX for a follow-up of XXXX-XX injury. XXXX stated that XXXX was doing well. XXXX found that the wound was healing well with no sign of infection. XXXX had full flexion and extension of the digits and no extensor lag of the XXXX XX. X-rays of the XXXX XX dated XXXX showed soft tissue XX of the XX of the XX. There was no evidence of fracture. The treatment to date included wound wash with soap and water, dry gauze, medications (XX), XX, XX therapy, and XXXX XX XX repair XXXX. Per a peer review dated XXXX and utilization review decision letter dated XXXX, the requested service of XX therapy XX times per week for XX weeks for XX / XX including XXXX XX was denied by XXXX. XXXX documented that XXXX already had been authorized for XX sessions of XX therapy for the rehabilitation of the XXXX XX XX tendon lacerations. Therefore, additional XX therapy was not medically necessary. Per a peer review dated XXXX and a utilization review decision letter dated XXXX, the prior decision was

upheld by XXXX. Rationale: "As per Official Disability Guidelines (ODG), XX, XX and XX, Online Version, (Updated XX), XX / XX Therapy, 'Post-surgical treatment / tendon repair: XX visits over XX weeks." The patient is a status post XXXX XX tendon to the XXXX XX repair on XXXX. The examination revealed a XX range of motion. XXXX was previously authorized for XX sessions of XX therapy. XXXX has not completed all prior XX therapy sessions and the outcomes are not documented at this time. In consideration of the foregoing issues and the referenced guidelines, the medical necessity of the requested XX XX therapy visits is not established at this time. This request was previously not certified on XXXX for these reasons, which have yet to be addressed. The request is not certified and not medically necessary."

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 XX therapy XX times per week for XX weeks for XX / XX including XXXX XX is not recommended as medically necessary. Per a peer review dated XXXX and utilization review decision letter dated XXXX, the requested service of XX therapy XX times per week for XX weeks for XX / XX including XXXX was denied by XXXX. XXXX documented that XXXX already had been authorized for XX sessions of XX therapy for the rehabilitation of the XXXX XX XX tendon XX. Therefore, additional XX therapy was not medically necessary. Per a peer review dated XXXX and a utilization review decision letter dated XXXX, the prior decision was upheld by XXXX. Rationale: "As per Official Disability Guidelines (ODG), XX, XX and XX, Online Version, (Updated XX), XX / XX Therapy, 'Post-surgical treatment / tendon repair: XX visits over XX weeks." The patient is a status post XXXX extensor tendon to the XXXX repair on XXXX. The examination revealed a reduced range of motion. XXXX was previously authorized for XX sessions of XX therapy. XXXX has not completed all prior XX therapy sessions and the outcomes are not documented at this time. In consideration of the foregoing issues and the referenced guidelines, the medical necessity of the requested XX XX therapy visits is not established at this time. This request was previously not certified on XXXX for these reasons, which have yet to be addressed. The request is not certified and not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient has been authorized for XX postoperative XX therapy visits to date. Current evidence-based guidelines support up to XX sessions of XX therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. Additionally, based on the scheduling form, it appears that the previously authorized sessions will not be completed until XXXX. Thus, the patient's objective functional response to authorized XX therapy is unknown at this time. The request for XX sessions is excessive and does not allow for adequate interim follow up to assess the patient's response to treatment.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is upheld.

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 LOW BACK 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