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Date: 12/5/2018 2:53:08 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX

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

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. The mechanism of the injury was detailed XXXX. XXXX and was transferred to the hospital, where XXXX was determined to have a XX-XX XX of the XXXX XX at the level of the XX XX. XX and repair of the injured structure were performed, including XX of XX to XX bones, extensor / flexor XX repair, and repair of XX XX. XXXX was diagnosed with partial traumatic XX XX of the XXXX XX, subsequent encounter (XX.XX). XXXX was evaluated by XXXX on XXXX in a follow-up. XXXX had significant XX and decreased strength in the XXXX XX that affected the ability to perform work tasks and XX-XX tasks involving the use of XXXX XX. XXXX reported that XXXX. XXXX was unable to manage XX or XX during XX tasks. XXXX reported difficulty with using XX with the XXXX when XX. XXXX was able to grasp a XX of XX with the XXXX XX but was primarily using XXXX XX XX to perform XX tasks. XXXX was not XX at the time. XXXX was XX a XX daily but was instructed to XX the XX only at XX for protection. On examination, XXXX was unable to perform XX tests secondary to acuteness of the injury and ongoing integrity of the affected joints. XXXX revealed increase progress towards strength and functional goals including buttoning, key pinch, manipulating small objects with the XXXX XX, and increased activity tolerance. XXXX continued to have deficits regarding strength, range of motion pertaining to carrying on the affected side, using tools for work (XX, XX), pushing / pulling, and carrying XX. XXXX had progressed to a home exercise program and demonstrated good understanding. The therapist

observed a decrease in the XXXX XX active range of motion during functional XX tasks causing decreased ability to clasp XX and lift overhead with XX required at work. It was recommended to add the XXXX XX into the treatment plan for ability of return to work full duty. Skilled XX intervention was also recommended to address the above deficits and outlined goals. The Orebro Musculoskeletal Screening Questionnaire (OMSQ) score was XXXX and Disabilities of Arm, XX, XX (DASH / QDASH) score was XXXX. An undated x-ray revealed mild XX along the XX site. The treatment to date included repair of the XXXX injury, XX sessions of XX therapy / XX therapy, and a XX XX XX. Per a utilization review decision letter dated XXXX, the request for additional XX therapy was denied. According to the documentation, XXXX participated in XX sessions of XX therapy. On XXXX, it was documented that XXXX continued to complain of pain during gripping items. It was documented that XXXX was also unable to grip "appear requires." The documentation indicated that XXXX continued to work light duty. Rationale: "The clinical documentation submitted for review does indicate that the patient has participated in approximately XX sessions of XX therapy. The documentation does indicate that the patient has not met long-term goals. However, the documentation does not identify that the patient has factors that would inhibit progress during a normal course of therapy. The patient should be well-versed in a home exercise program. There are no factors to preclude further progress of the patient while participating in a home exercise program. The need for direct supervision versus oversight by the physician is not detailed in the information submitted. As such, the requested additional XX therapy XX times a week for XX weeks is not certified." Per a utilization review decision letter dated XXXX, the prior denial was upheld. The request was previously denied due to no factors to preclude further progress of XXXX and XXXX would participate in a home exercise program. It was noted that XXXX was XX a XX XX daily but was instructed to XX the XX only at XX for protection. It was also noted that XXXX had completed XX sessions of XX therapy. Documentation revealed that XXXX did not meet long-term goals. However, XXXX had exceeded the guidelines' recommended amount of XX therapy for XXXX injury. It was also not indicated as to why XXXX could not benefit from a home exercise program alone versus more XX therapy. As such, the request for additional XX therapy was non-certified.

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 Additional XX therapy XX times a week for XX weeks, XX: Patient re-evaluation established plan care, XX: Therapeutic exercises and treatment for strength and movement recovery, XX: Re-learning XX movement, XX: Manual therapy techniques, each XX minutes, requiring direct contact with physician or therapist, XX: Therapeutic activities that involve working directly with the provider, XX: Group therapeutic procedures is not recommended as medically necessary. The submitted clinical records indicate that the patient has completed XX 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. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented.

The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program

as recommended by the guidelines. Therefore, the request is not medically necessary and upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF XX & 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