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**12/06/18**

***Description of the service or services in dispute:***

*XX*

***Description of the qualifications for each physician or other health care provider who reviewed the decision:***

Board Certified Occupational Medicine

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

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

***Patient Clinical History (Summary)***

*XXXX who was diagnosed with other XX of XX XX, subsequent encounter (XX.XX); XX of other ligament of XX XX; XX of unspecified parts of XX XX XX; pain in the XX XX; and XX of the XX XX. XXXX.*

*XXXX was seen by XXXX for the complaints of XX XX and XX, and for pain and burning sensation towards the XX. The pain was rated at XX/10. XXXX reported that overall the complaints had remained the same. XX gait, pain level, range of motion, XX, XX, and strength had remained the same. The swelling had decreased. Examination of the XX XX / XX revealed decreased XX. The range of motion during XX, XX, inversion and eversion remained the same. There was a XX noted over the XX XX surface of the XX. The muscle testing showed increased XX and XX. XXXX was referred to XX therapy for evaluation and treatment. XXXX was placed on restricted duty.*

*XXXX underwent XX therapy initial evaluation on XXXX for the complaints of XX XX / XX. The pain was rated at XX/10 in the XX to XX XX and XX/10 when putting weight through the XX. On examination, XXXX was seen XX with decreased XX XX and XX off throughout the XX cycle. The XX straight XX stance test was XX seconds and the XX straight XX stance test was XX seconds. There was a XX XX present over the XX XX joint. Passive range of motion of the XX XX was painful. Active range of motion of the XX XX showed XX degrees XX, XX degrees XX with XX stretch pain, XX degrees inversion with pain, and XX*

*degrees eversion with pain. Muscle strength was decreased in the XX XX joint. Active extension of the first XX XX joint was XX degrees with XX. XX to palpation was noted over the first to XX XX joint, around the XX XX, medial / XX XX, and XX XX muscles. There was significant XX noted in "A/P, P/A" with XX joint glides grade XX-XX. It was opined that XXXX displayed an increased complication potentially due to surgery. XXXX had significant ankle stiffness and an enlarged XX over the first XX joint.*

*XXXX was evaluated by XXXX for the complaints of XX XX and XX. XXXX continued to feel a burning sensation. The pain was rated at XX/10. XXXX reported that overall the complaints had remained the same. There was no XX gait reported. Pain level, range of motion, XX, XX, and strength had remained the same. The XX had decreased. The examination of the XX XX / XX revealed no XX. The range of motion during XX, XX, inversion and eversion remained the same. There was sensitivity noted over the XX. The muscle testing showed increased XX. There was a decrease in XX since the prior injection, per the podiatrist. XXXX was to continue XX therapy to decrease pain and improve function. A prescription was provided for XX visits of XX therapy XX times a week for XX weeks. Referrals were also provided to neurology and XX. XXXX was instructed to continue restricted duty.*

*An MRI of the XX XX dated XXXX showed bone XX / XX XX of the XX of the XX XX XX and extensive soft tissue XX.*

*The treatment to date consisted of XX therapy, open reduction and internal fixation of the XX fracture, use of XX, XX XX, use of XX, medications (XXXX), XX management with injections, and nonweightbearing status.*

*A letter of medical necessity dated XXXX indicated, the proposed treatment (XX therapy XX times weekly or per schedule) was necessary and would help XXXX to heal and ultimately return to normal work duties. The proposed treatment was necessary for XXXX's medical condition.*

*Per an Initial Utilization Review Adverse Determination letter dated XXXX, the request for XX sessions of XX XX / XX therapy was denied by XXXX. The principle reason for denying these services or treatment was as follows: "Review of the records revealed that XXXX is a XXXX. The reported mechanism of injury was XXXX. XXXX was diagnosed with XX XX /XX XX. XXXX has a complaint of XX XX pain. XXXX is status post XX XX with XX XX (XX) of a XX fracture on XXXX. XXXX has been attending XX therapy. The clinical note dated XXXX reviewed. The pain level was rated XX/10. XXXX reported that pain was the same. The exam showed unchanged XX motion, XX over the XX XX XX at a XX, and normal gait. XXXX was released to restricted duty. On XXXX, reportedly did not place XXXX at maximum medical improvement (MMI)." The clinical basis for denying these services was as follows: "Spoke with XXXX. XXXX stated that XXXX has seen XXXX twice. XXXX had treatment at a different location. XXXX is seeing a XX and a XX surgeon. The plastic surgeon had recommended continued XX therapy. XXXX has a XX over the XX from the open reduction internal fixation (ORIF) surgery. XXXX stated that XXXX had received benefit from the prior therapy. XXXX has reportedly attended XX sessions of XX therapy. It is unclear what progress has been made with the prior treatment. It is unclear what deficits are still present that might be amenable to treatment with continued monitored therapy. There is an inadequate reason for additional XX therapy. Therefore, the request for XX sessions of XX XX/XX therapy is non-certified." The screening criteria and treatment guidelines used to make the determination was "ODG XX and XX (XXXX), XX Therapy."*

*Per a Reconsideration Review Adverse Determination letter dated XXXX determined that the request for XX sessions of XX therapy for the XX XX / XX did not meet the medical necessity guidelines. Rationale: "XXXX. The reported mechanism of injury XXXX. XXXX was diagnosed with XX XX / XX XX. XXXX has a complaint of XX XX pain. XXXX is status XX  XX with XX XX (XX) of a XX fracture on XXXX. XXXX has been attending XX therapy. The clinical note, dated XXXX revealed that the pain level was rated at XX/10. XXXX reported that pain was the same. The exam showed unchanged XX motion, tenderness over the medial XX XX at a XX, and normal gait. XXXX was released to restricted duty. On XXXX, reportedly did not place XXXX at maximum medical improvement (MMI). A clinical note, XXXX, reported that XXXX complained of XX/10 pain on the XX XX, and still felt burning. Physical examination revealed vascular intact, no edema. The range of motion with XX and XX remained the same. Inversion / eversion were the same. No tenderness was noted. There was sensitivity over the XX. Muscle testing with XX was XX. There was a decrease in XX since last injection, per podiatrist. Recommendations were to continue XX therapy to decrease pain and improve function as recommended by "DD". No "DD" report provided. Treatment to date included, x-ray, MRI, XX therapy, and medications. The current request is for XX sessions of XX XX / XX therapy. At the time of submission, there has not been a successful peer to peer. Based on the clinical information provided, the appeal request for XX sessions of XX therapy for the XX XX / XX is not recommended as medically necessary. There is insufficient information to support a change in determination, and the previous noncertification is upheld." "XXXX has completed XX sessions of PT to date. The ODG support up to XX sessions of XX therapy for XXXX'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. XXXX 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. The clinical information provided does not support medical necessity and the request is non-certified." The description of the source of screening criteria is "ODG, XX and XX (updated XXXX), XX Therapy (XX).*

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

Per XX therapy daily note dated *XXXX*, the patient had completed XX total XX visits for diagnoses of other XX of XX XX, XX of other ligament of XX XX, XX of unspecified parts of XX XX XX and pain in XX XX. The patient had been recommended for XX additional XX therapy sessions for the XX XX/XX. However, the Official Disability Guidelines Treatment Index, 23 rd edition online, 2018-XX and XX Chapter notes that up to XX sessions of XX therapy over XX weeks would be supported for the patient's presenting diagnosis. It is unclear how additional supervised XX therapy visits would significantly benefit this patient versus a home program. Recommend non-certification for the request as the requested service(s) is considered not medically necessary based on the medical records submitted.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

☐ ACOEM-America College of Occupational and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐

☐

DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines

☐ ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT.
**Ankle/foot Sprain**:
Medical treatment: 9 visits over 8 weeks
Post-surgical treatment: 34 visits over 16 weeks

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

**Appeal Information**

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.