US Decisions Inc.

An Independent Review Organization
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Description of the service or services in dispute:

Denial of XX of XX visits for XX, denial of XX care recommended / referred by initial treating doctor.
XX - Application of XX XX, without direct provider contact, each XX XX
XX - XX XX
XX - Application of XX XX not requiring direct contact with the provider
XX - Therapeutic exercises and treatment for strength and movement recovery

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

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. XXXX was diagnosed with XX of muscle, XX, and tendon of the XX XX, initial encounter (XX.XX).

XXXX. XXXX reported that XXXX had pain in the XX and XX XX. The XX XX pain was mostly a XX XX with a general XX, but with occasional XX with movement. The XX pain was mostly XX and had been getting worse since the XX. XXXX noted XX and XX in the XX XX XX in the first few days after the XX but was not experiencing those symptoms at the time. XXXX had XX in the XX XX, general XX, and XX. XX, XXXX noted that XXXX active range of motion in the XX XX was reduced on extension and XX XX flexion with pain. XX XX was noted in the XX and XX XX XX and over the XXXX and XXXX XX joints, and muscular XX was noted in the XX and XX XX XX and in the XX XX XX. Lasegue's test and Ely's test were XX for XX pain XX. Resisted muscle testing of the XX XX showed XX strength with associated pain on XX extension and XX flexion XX. XXXX was observed changing position while seated

to reduce XXXX XX pain. XX restrictions were noted in the XX and XX XX and both XX joints. XXXX recommended XX visits per week for XX weeks, a total of XX visits.

An MRI of the XX XX dated XXXX showed no significant findings. A CT of the XX XX was also unremarkable.

The treatment to date included medications (XXXX), XX therapy, XX therapy, and XX.

Per a utilization review decision letter and a peer review dated XXXX, the requested service of XX sessions of XX therapy / XX care for XX XX was denied by XXXX. Rationale: "The Official Disability Guidelines recommend XX sessions of XX treatment for patients with moderate-to-severe pain. The clinical documentation submitted for review does indicate that the patient has XX out of 10 pain. However, the documentation submitted for review does not provide an objective evaluation of the patient's XX XX. Therefore, it is unclear how objective functional improvements will be documented. I discussed the case with XXXX. XXXX stated that XXXX was unsure about the patient's past experience with XX therapy. No new clinical information was discussed during our peer-to- peer discussion and XXXX did say XXXX would re-assess the patient and submit further documentation."

An appeal letter was written by XXXX. XXXX documented that XXXX was referred by XXXX and was initially seen on XXXX. The Officially Disability Guidelines (ODG) XX Therapy guidelines allowed for XX visits over an XX-week period for a XX XX / XX (as diagnosed by XXXX). XXXX had received only XX visits of care at XXXX. Out of those XX visits, XXXX received active care for a total of XX visits and received no further care as XXXX was denied additional visits. Some form of XX care was rendered each visit. XXXX did not receive any additional therapy or care for these injuries after XXXX. XXXX opined that the gaps in XXXX treatment have contributed to worsening XXXX condition. Furthermore, XXXX received only XX procedures on each of XXXX therapy visits. None of which included XX care. XXXX opined that the treatment plan was designed to improve as rapidly as possible so that XXXX might return to work. The denial of services to XXXX was XX and XX-XX. XX therapy visits for someone with XX/10 pain and a mechanism of injury such as XXXX was nowhere near enough for XXXX to XX sufficiently.

Per a utilization review decision letter and a peer review dated XXXX, the prior denial was upheld by XXXX. Rationale: "This request was previously non-certified by XXXX on XXXX, as the current request exceed the guidelines and there was no documentation of clinical examination findings of the XX XX made available for review. No additional documentation was provided to support the request. The previous non-certification is supported. According to the guidelines, XX therapy for a XX strain is recommended to XX treatment sessions over XX weeks and the current request exceeds the recommended guidelines. XXXX has already completed XX or XX XX therapy sessions for the XX XX and there was no medical reason provided as to why XXXX could not be transitioned into active participation in a home exercise program. Also, there were no clinical examination findings of the XX XX from the treating physician made available for review to support the request. The case was discussed with XXXX. XX additional therapy visits were recommended to stay within the guidelines; however, XXXX did not accept this as an option."

Per an appeal letter dated XXXX by XXXX, the "peer-to-peer" reviews with XXXX and XXXX was extremely disappointing. XXXX report also stated that 'XX additional therapy visits were recommended' and that 'XXXX did not accept this as an option'. XXXX never told that this was the only option. XXXX stated that "XXXX letter also notes that the 'supporting criteria' for this review was 'ODG guidelines' and 'Clinical Judgment/ Accepted Practices'. First off, ODG guidelines call for XX visits, not XX. ODG guidelines don't appear to have been followed initially, so I'm confused as to why they would be cited this time. As far as clinical judgment goes, I don't believe that XXXX has EVER seen this patient. To my knowledge, XXXX has not interviewed or interacted with XXXX and it says as much in XXXX final statement". XXXX also stated that "XX by XXXX and XXXX and XXXX. I also feel as though that the initial denial of XXXX care with XXXX (that is a denial of the ODG mandated XX visits) was XX and served to compound XXXX injury."

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 is medically necessary, and the previous denials are overturned. ODG guidelines call for XX visits, not XX therapy visits. The submitted clinical records indicate that the patient has completed only XX XX therapy visits to date. Current evidence-based guidelines support up to XX visits for the patient's diagnosis. XX additional visits of therapy is in accordance with the Official Disability Guidelines and should be afforded to the patient to treat XXXX work-related injury. Given the clinical data presented, there is sufficient information to support a change in determination, and the request is certified. Therefore, medical necessity is established in accordance with current evidence-based guidelines.

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
- ☐ 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.