Clear Resolutions Inc.

An Independent Review Organization
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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 Orthopedic Surgeon

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 other XX, XX

XXXX. XXXX had been diagnosed with XX of the XX and referred to XX therapy by XXXX. XXXX was status post XX on XXXX. XXXX complained of pain, XX, XX, and XX. XXXX reported difficulty with following functional activities: XX XX and XX. The pain was located in the XX XX XX, and XX including XX. It was constant and rated at XX/10. It was rated at XX/10 with rest and XX/10 with activity. XXXX was not working at the time. On examination, XX was noted. XX over the XX noted an area of XX formation along the XX without swelling. Active range of motion of the XX was deferred. Active range of motion of the XX demonstrated XX on the XX and XX degrees on the XX; extension XX degrees XX; abduction XX degrees on the XX and XX degrees on the XX; internal rotation XX degrees on the XX and XX degrees on the XX; and XX rotation XX degrees on the XX and XX degrees on the XX. Active range of motion of the XX revealed flexion XX degrees on the XX and XX degrees on the XX and extension of XX degrees XX. Flexibility testing of XX XX XX and XX was moderate. The muscle strength was XX/5 of the XX XX (XX-XX), XX abductors, and XX adductors XX. Strength testing of the XX XX was deferred XX. Per the note, XXXX did not indicate any adverse response to XX therapy evaluation. XXXX perceived level of disability based on the XX XX XX Questionnaire was XX%. XXXX was instructed for concerns regarding area of XX along the XX, which appeared to be issue, XXXX could follow-up with XXXX surgeon. XXXX demonstrated deficits with XXXX lower XX of motion / flexibility and strength with precaution for active range of motion assessment of the XX XX until XX weeks postoperative. XXXX also

had lifting XX to exceed XX pounds. XXXX exhibited the following deficits that could be addressed by XX therapy: XX XX pain, XX XX pain, (XX at XX extremity, decreased range of motion of the XX extremities with precautions for XX XX, decreased XX, decreased XX decreased XX of XX living and functional activity, decreased balance and proprioception, decreased activity tolerance, lack of understanding of diagnosis and exacerbating factors, and lack of understanding and knowledge of proper body mechanics and joint protection techniques to prevent further injury. Per an addendum to the note, XXXX documented that XXXX received XX therapy prior to surgery with initial evaluation on XXXX and completed XX visits – all completed at XXXX. However, XXXX was returning to therapy having undergone a surgical procedure, which should warrant appropriate postoperative therapy for XXXX diagnosis based on Official Disability Guidelines and medical necessity.

Per an office visit note dated XXXX, XXXX visited XXXX for a XX visit. XXXX was approximately XX weeks status post XX-XX XX and reported XX% improvement from XXXX preoperative symptoms. Detailed XX examination noted the strength and sensation to pin were grossly intact XX. XXXX noted XXXX was doing well postoperatively and the incision was healing well. XXXX was to continue XX precautions, continue increasing ambulation and mobilization, begin gentle range of motion exercises, continue pain medication as needed, and start in XX XX therapy.

A functional capacity evaluation was completed on XXXX. The results of the evaluation indicated that XXXX did not demonstrate the ability to meet the medium physical demand requirements of XXXX. XXXX demonstrated the ability to function at a light physical demand level according to the XX. Deficits identified during testing included range of motion of the XX XX, XX XX strength, XX. XXXX demonstrated consistent and full effort throughout testing. Based on the outcome of the functional capacity evaluation performed, XXXX had remaining physical impairments that limited XX from returning to a medium physical demand level without restrictions. XXXX opined XXXX may be a candidate for a work conditioning program to restore XXXX physical capacity and function to enable XX to return to XXXX pre-injury physical demand level.

Per a Designated Doctor Examination report dated XXXX, there were no further treatment recommendations for the accepted conditions of a XX strain, XX contusion, XX strain, and XX sprain. It was noted that XXXX had reached maximum medical improvement on XXXX. Impairment rating for the XX XX sprain / strain was XX% whole person impairment and 5% whole person impairment for the XX XX contusion, strain, yielding combined 5% whole person impairment.

An MRI of the XX XX dated XXXX showed mild XX XX at XX-XX with XX XX and mild XX XX at XX-XX. EMG / NCV of the XX XX XX performed on XXXX was within normal limits.

The treatment to date included rest, medications including XXXX; XX therapy; an injection in the XX XX (XX% pain relief and improved range of motion in the XX and XX XX); and XX XX-XX XX on XXXX (XX% improvement from XX symptoms).

Per a utilization review decision letter dated XXXX, the request for XX hours of work conditioning program between XXXX. Rationale: "This patient has chronic pain that prevents return to work for XX months. XX barriers like pain behaviors are a XX for enrolment into XX XX. There are no exceptional factors."

Per a utilization review dated XXXX, the requested service of XX hours of XX XX program between XXXX., MD. Rationale: "XX. The patient's PDL was light and XXXX work PDL was noted medium. XXXX was recommended XX XX program. However, given the chronicity of the injury, there was limited documentation that the patient had tried and failed to XX therapy as there was no XX therapy report submitted for review. In addition, a specifically defined return-to-work goal or job plan was not clearly addressed. Peer to peer conducted with peer designee, XXXX and case discussed. Per XXXX office visit progress note by XXXX, the plan was to refer the patient for work conditioning. XXXX XX (XX) score was XXXX which is consistent with XX. The XX-II (XX-II) score was XXXX, which is consistent with moderate XX. XX XX programs are generally indicated for those with mild XX to recovery. Based on the information provided, guidelines reviewed and peer discussion, the request is not medically supported at this time and thus, non-certified."

Per a utilization review decision letter dated XXXX, the requested service of XX sessions of XX therapy for the XX XX with re-evaluation between XXXX with the following rationale: "XX. In this case, the patient complained of pain, XX. XXXX was certified with XX XX Therapy Visits for the XX XX. However, there were no documented completed XX therapy visits to date to determine if the current request exceeds the guidelines recommendation. The objective findings documented were limited to validate patient's response and establish efficacy from the prior XX therapy. Exceptional factors could not be clearly identified. Telephone contact was established with a provider designee for the office of XXXX. It is reported the patient did not start therapy until after XXXX, but it is thought that XXXX is currently in therapy that was previously approved. No comparison evaluations are available to support a need for more supervised care with this information."

Per a utilization review decision letter dated XXXX, the concurrent request for XX sessions of XX therapy for XX XX with re-evaluation between XXXX. Rationale: "Per guidelines, the recommended number of XX therapy (XX) visits for Post-surgical treatment (XX/XX) is XX visits over XX weeks. In this case, the patient complained of pain, XX. XXXX was certified with XX XX visits for the XX XX on XXXX. However, there were no XX reports submitted for review of XXXX XX sessions of XX to warrant another XX sessions as per guidelines, the patient should be formally assessed after a XX-visit clinical trial to see if the patient is moving in a positive direction, no direction, or a negative direction prior to continuing with the XX therapy."

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

The ODG supports up to XX visits of XX therapy for the postsurgical treatment of XX. The documentation provided indicates that the injured worker is status post XX XX/XX XX on XXXX. The injured worker was certified for XX visits of XX therapy postoperatively. The

documentation includes a XX therapy evaluation on XXXX which indicates that the injured worker is following up to resume XX therapy after XX intervention. An assessment indicates decreased range of motion of the XX XX and decreased strength in hip XX on the XX. There are no additional XX therapy notes to indicate that the injured worker has had improved pain and function with the initial XX visits of XX therapy. There is a request for an additional XX sessions of XX therapy. A prior review on XXXX recommended noncertification for the additional XX sessions as there was no documentation to indicate that the patient was moving in a positive direction with the initial XX visits of XX therapy. Based on the documentation provided, the original denial should be upheld as there is no additional documentation indicate that the injured worker has had improved pain and function with the initial XX certified visits of XX therapy. As such, medical necessity has not been established.

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 XX XX 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

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☐ 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.