MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

DATE OF REVIEW: October 30, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of XX XX XX XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a board-certified Orthopedic Surgeon who is currently licensed and practicing in the State of Texas.

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

☒ Upheld

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX. Office visit dated XXXX, reported the claimant had an MRI of XXXX XX XX on XXXX which revealed a XX XX with retraction to the level of the XX, XX, XX by the XX joint, XX XX, and XX pouch. X-rays dated XXXX revealed XX by the XX joint. Office note dated XXXX reported the claimant had conservative treatment with XX medications, XX therapy, and a home exercise program but pain and problem persisted. On XXXX, the claimant underwent repair of XX XX, XX XX, XX, XX, and XX XX. A postoperative office visit dated XXXX documented the claimant to have complaints of decreased range of motion. Objective findings on physical exam revealed XX were well-healed without signs of XX. There was no XX, XX, XX, XX, XX, or XX. The XX was XX degrees, passive XX of XX degrees, XX degrees and XX XX degree. The motion strength was XX/5, XX XX flexion and XX. The impression was status XX XX of XX XX XX XX and XX XX. The plan of treatment included more physical therapy and XX to help with XX of XXXX XX.

Prior UR letter dated XXXX denied the request for coverage of XX XX XX due to "clarification is needed regarding the length of use of the device whether it is for rental or additional use. These were not clearly specified in the request. In addition, the guidelines stated that XX XX XX for any indication is considered experimental, investigational or unproven. No high-quality evidence is yet available."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The claimant is a XXXX who was diagnosed with XX XX XX XX XX XX XX XX and XX XX XX. The request is for coverage of XX XX XX.

The Official Disability Guidelines (ODG) regarding the use of XX is under study for XX XX, but it is an alternative option in conjunction with continued XX therapy if XX weeks of XX therapy (XX) alone has been clearly unsuccessful in adequately correcting range of motion limitations XX XX, otherwise needing manipulation and/or XX. In this case, the medical records documented the claimant continues to have decreased XX XX XX of motion and has been diagnosed with XX XX. The XX XX XX was prescribed to help with passive stretching of XXXX XX XX along with continued XX therapy program. However, the duration of recommended use of XX is not provided and not documented whether it is for rental or additional use. The documentation of the claimant's specific XX therapy regimen and notes from the XX therapist are also not provided for this review. Additionally, the medical literatures on the use of XX devices (XX) for treatment of XX is minimal and limited to a few retrospective case series. The ODG have limited indications for its use and consider the use of the device as investigational/experimental.

Therefore, based on lack of sufficient medical evidence, review of ODG, and the clinical documentation as stated above, the request for coverage of XX XX XX is not medically necessary and appropriate.

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

High-intensity XX for XX XX of the XX. XX, XX, XX, XX. A XX. XX XX

Efficacy of a static XX as an adjunct to XX therapy in treating XX of the XX: a prospective, randomised study. XX.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
XX – Updated (XX) – Online Version
XX®

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.