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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 03/19/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Authorization and coverage for XX visits of Therapeutic Exercises XXxXX, for XX, XX XX and XX XX.

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

M.D., Board Certified in Chiropractic and Acupuncture.

REVIEW OUTCOME

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

☒Upheld (Agree)

☐Overturned (Disagree)

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

I have determined that the requested is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The requesting provider's XX evaluation failed to establish a clear record of what prior treatment had transpired with no mention made as to prior treatment if any administered to include recommendations for home-based exercise and whether any functional improvement had been

established, criteria for the reference guidelines for consideration of additional treatment/exercise.

The evaluation report cited the patient with a visible XX with increased pain on the XX, XX range of motion pain at 6/10, range of motion of the XX XX in flexion 40% maximum which was 80% of normal and extension at 50% of normal and lateral bending XX at 44% of normal and XX lateral bending at 55% of normal. Remaining testing focused on the XX XX including XX flexion at 50% extension – 8° maximum. The reporting provider recommended a rehabilitation program which emphasized strengthening, range of motion conditioning exercises, XX visits or therapeutic exercises so together the provider could bring 18th resolution to this matter.

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

The ODG Treatment Guidelines for XX and Upper XX XX online version recommend mechanical disorders of the XX therapeutic exercises and have demonstrated significant benefit terms of pain, functional restoration and partial global assessment scales. Low stress aerobic activities and stretching exercises initiated at home and supported by a XX therapy provider are also recommended to avoid the XX and further restriction of motion.

The reviewed records from the provider did not identify any specific impairment or restriction in the XX XX, XX XX or XX that would preclude the patient from engaging in a home exercise program after proper instruction. The medical necessity for a managed XX visits XX therapy/exercise rehabilitation program is not supported by the reviewed documentation from the requesting provider or referenced ODG Treatment Guidelines for XX and Upper XX and XX.

Therefore**,** I have determined the requested is not medically necessary for treatment of the patient's medical condition.

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

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**