Clear Resolutions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX therapy, XX times per week for XX weeks.
XX - Under XX Therapy Evaluations
XX - Therapeutic procedure, XX or more areas, each XX minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
XX - Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
XX - Manual therapy techniques, each XX minutes, requiring direct contact with physician or therapist
XX - Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each XX minutes
XX - Therapeutic procedure(s), group (XX or more individuals)

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

Board Certified Orthopedic Surgery

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)

XX. XX XX is a XX-year-old XX who sustained a work-related injury on XX. XX was diagnosed with XX injury of XX XX, subsequent encounter (XX.XX). XX reported that while XX was working on XX XX XX, XX a XX XX from the XX, the XX-XX-XX XX came XX and XX onto XX XX XX, resulting in a XX injury.

On XX, XX. XX was evaluated by XX for initial evaluation of the XX-XX injury that XX injured at work on XX. XX complained of XX-XX sharp pain rated as 6/10. There was bruising and numbness or tingling. The XX XX examination showed circulation, sensation, and motor examination was intact distally including median, XX, and radial nerve distributions. There was no deformity or abnormality visible other than mild swelling. XX range of motion showed 45 degrees of extension, 30 degrees of flexion, 80 degrees of supination and 70 degrees pronation. XX flexion was to XX cm from the XX XX crease (XX). XX extension was to 20-30 degrees XX joints. An MRI showed XX fracture, numerous contusions, and possible XX ligament (XX) and XX XX complex (XX) sprains. The diagnosis was closed nondisplaced XX of XX of XX XX, initial

encounter. XX discussed range of motion exercises and provided a referral to XX therapy for aggressive range of motion. On XX, XX. XX appeared to be in good health. Circulation, sensation and motor examination was intact distally including median, XX and radial nerve distributions. There was no deformity or abnormality visible. XX showed flexion to XX cm from the XX XX crease, and 30 degrees of flexion and extension of the XX with 90 degrees supination and 70 degrees pronation. An Excuse for Work note was provided by XX stating that XX. XX would remain off work from XX through XX. XX was placed on light duty work status and was restricted from lifting of any pounds of weight.

On XX, a work excuse note was provided by XX stating that XX. XX would need to be out of work from XX to XX, and XX would return to work on XX.

An MRI of the XX XX dated XX revealed acute fracture of the XX, additional acute XX XX of the XX, XX, XX and XX XX base. There was suspicion for grade 1/2 sprain of the XX ligament, possible nondisplaced tear / perforation of the XX XX, and suspicion for grade 1/2 strain of the abductor XX XX, XX XX XX and XX XX muscle.

Treatment to date consisted of medications (XX) and XX therapy. The submitted XX therapy documentation indicates that as of XX the injured worker completed XX therapy sessions following a XX XX injury to the XX. The therapist noted improvement several with active range of motion, but persistent XX was documented. The therapist recommends XX additional therapy sessions.

Per an Adverse Determination letter dated XX by XX, the request for XX therapy three XX a week for XX weeks of the XX XX was noncertified. Based on the clinical information provided, the request was not recommended as medically necessary. It was determined that there was no comprehensive assessment of treatment completed to date or XX. XX response thereto submitted for review. The total number of therapy visits completed to date was not documented. Ongoing evidence-based guidelines would support up to XX sessions of therapy for XX. XX diagnosis, and there was no clear rationale provided to support exceeding the recommendation. Therefore, medical necessity was not established in accordance with the ongoing evidence-based guidelines. Per an addendum, XX documented, "I spoke to XX on XX at XX PM XX. Patient has not had any OT thus far. XX has not had XX thus far. She stated the doc was worried about the recovery of range of motion and that is all she knew. No extenuating circumstances were given to exceed the guideline recommendation. There is insufficient information to support a change in determination, and the previous noncertification was upheld."

Per a utilization review determination letter dated XX by XX, the request for XX therapy XX times a week for XX weeks of the XX XX (CPT codes XX, XX, XX, XX, XX, XX) was denied. Rationale: A request for XX therapy XX x week x XX weeks XX XX XX, XX, XX, XX, XX, XX was made; however, the current request in addition to the previous authorization exceeds the guideline recommendation. There are no exceptional factors to support ongoing supervised therapy versus maintenance home exercise. Based on the fact that the claimant is still in the XX healing phase, about XX months, and without clinical indications for need for excessive XX sessions of XX without a shorter trial of XX sessions to determine efficacy and compliance. And the lack of extenuating circumstances to exceed Guideline and considering the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified."

A review summary dated XX by XX and a utilization review determination letter dated XX, indicated that the reconsideration request for additional XX therapy XX times a week for XX weeks for the XX XX (XX, XX, XX, XX, XX) was denied /

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noncertified. It was determined that per evidence-based guidelines, the recommended XX therapy visits for a XX injury of XX / XX was XX visits over XX weeks. In XX. XX case, XX had a XX XX / XX pain rated as 6/10 as XX ongoing pain, 5/10 at its best, and 8/10 at its worst. XX had attended XX XX therapy visits to that time. However, the ongoing request in addition to the total attended sessions exceeded the state guideline recommendation. Moreover, a clear objective measure of functional gains from prior sessions was not fully established to support the continuation of the therapy. Clarification was needed regarding the request for continued therapy versus a home exercise program. The prior non-certification was upheld.

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

The ODG supports the utilization of XX and XX therapy as an option for management of XX type injuries of the digits and recommends up to XX sessions. In this particular case, at least XX sessions of XX therapy had previously been completed when the additional XX sessions were requested. This information did not appear to be available to the previous reviewers and during at least one peer to peer conversation, the physician assistant indicated that therapy had not previously been performed. The submitted XX therapy documents indicate significant evidence of objective functional improvement, but persistent deficits. Given the XX of the injury sustained, additional XX therapy would be reasonable to maximize functional outcome and to avoid surgical intervention. As such, deviation from the guidelines would be warranted and XX additional sessions would be considered appropriate to address the remaining deficits. There is no indication that XX additional sessions would be necessary at the time that the therapy was ordered. Given the documentation available, the requested service(s) is considered medically necessary in part. Partial certification is advised.

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

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Case Number: ***XX*** Date of Notice: 04/03/19

☐ 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 XX 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.

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