Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/10/2019 and amended 4/11/2019

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IRO REVIEWER REPORT

Date: 4/10/2019 and amended 4/11/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX Therapy and Custom fabricated XX

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who sustained a work-related injury on XX. XX was injured after XX on a XX XX XX and XX onto the XX XX XX. XX was diagnosed with a sprain of XX joint of XX XX, initial encounter (XX.XX). On XX, XX. XX was seen by XX XX, XX for XX XX pain. The pain was characterized as aching, dull, moderate, and abrupt. The associated symptoms were weakness and instability. The symptoms were aggravated with XX and XX. The alleviating factors included rest. XX. XX recommended XX-based orthotic for XX weeks. XX. XX underwent XX therapy initial evaluation at XX XX XX by XX XX, XX on XX for the diagnosis of tear of the XX XX XX at the XX (XX) joint level of the dominant XX XX. The pain was rated at 1/10 at the time, and it was 7/10 at the worst. XX. XX was working, but restricted to less than XX pounds of lifting. On examination, there was moderate XX over the XX XX, XX

aspect of the XX XX, and XX XX XX. Moderate point tenderness was noted to the XX XX XX (XX) of the XX XX XX joint. The XX XX had XX XX (XX) radial abduction of 36 degrees, XX XX XX of XX cm, and XX XX XX of XX XX XX to ruler cm. The XX XX (XX) flexion was 0-50 degrees and XX XX (XX) flexion was 0-61 degrees. XX - girth XX XX (IP) joint was XX cm. The pain had limited functional activities. The evaluation demonstrated decreased range of motion preventing full functional activity, decreased strength limiting functional activities, decreased participation in XX of XX XX, and deficit in functional scale score. The poorly scanned medical record was partially legible. Undated radiographs were negative. The treatment to date included XX therapy, XX XX XX, and restrictions. Per a utilization review decision letter dated XX, the request for XX therapy x XX visits and custom fabricated XX was denied by XX. A peer to peer was attempted, but not established. Rationale: "Regarding XX therapy, the ODG XX, XX, and XX recommend up to XX visits over XX weeks with an initial trial of XX sessions, and that given number of sessions be tapered and transition into a self-directed home program. The claimant has not started PT. XX continues with some restriction on the range of motion (ROM) testing, decreased strength, and pain. PT appears reasonable to restore motion, increase strength and decrease pain. However, XX legal statues require a successful peer to peer consensus agreement of proposed request modifications. As there has not been successful peer to peer, it is mandatory that the entire request must be non-certified. Recommend noncertification for XX therapy x XX sessions (XX). Regarding the request for custom fabricated XX, the claimant is diagnosed with a sprain of XX joint of the XX XX and has XX pain. On examination, there is restriction of XX motion and swelling. XX appears reasonable to protect an injured XX. However, no clear rationale provided for a XX XX. No extenuating circumstances. As there has not been successful peer to peer, it is mandatory that the entire request must be non-certified. Recommend noncertification for the custom fabricated XX." An Appeal was made by XX XX XX on XX for the adverse determination on the request for XX therapy and custom fabricated XX. Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: "Regarding the request for XX sessions of XX therapy, evidence-based guidelines allow up to XX sessions of therapy for patients who have sprains and stains of the XX and XX. In this case, the patient reported ongoing pain in the XX extremity, and the provider noted a XX XX ligament XX at the XX joint of the XX XX. Given guidelines recommendation for treatment, the request is reasonable and consistent with the evidence-based guidelines. However, given the state of jurisdiction, as not all requests were found to be consistent with guidelines, XX therapy x XX sessions (XX) is non-certified. Evidence-based guidelines indicate that XX may be recommended for the treatment of displaced fractures. In this case, the patient had a XX XX XX tear, and had been using an over-the-counter XX XX XX. However, as the patient had already been provided with an over-the-counter XX, the necessity for a custom fabricated XX is not established. There was no rationale indicating that the over-the-counter XX was ineffective, and that the patient specifically required a custom fabricated XX for pain relief. Custom fabricated XX is non-certified."

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 for XX therapy xXX visits and custom-fabricated XX, XX - Therapeutic exercises and treatment for strength and movement recovery, XX - Application of hot or cold packs, each XX minutes,XX - Manual therapy techniques, each XX minutes, requiring direct contact with physician or therapist, XX - Therapeutic activities that involve working directly with the provider, XX - Re-learning neuromuscular movement, XX - XX XX XX, without joints, may include soft interface, XX, custom fabricated, includes fitting and adjustment is not recommended as medically necessary, and previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. It is unclear if this is the initial therapy request for this patient. If it is the initial therapy request, guidelines would support an initial trial of only XX sessions of therapy to assess the patient's response to treatment and adjust the treatment plan accordingly. There is no rationale provided to support a custom XX for this patient versus a prefabricated XX. Additionally, the Official Disability Guidelines note that no more than XX to XX modalities should be utilized per session.

Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL