C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 387-2647
Email: resolutions.manager@ciro-site.com

Review Outcome

Description of the service or services in dispute:

XX therapy to the XX XX, XX x XX weeks, XX sessions.

XX - Therapeutic procedure, XX or more areas, each XX minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

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

Board Certified Chiropractor

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 suffered an injury on XX. XX XX and XX injuring XX XX, XX XX, and XX and was diagnosed with unspecified injury (XX.XX). XX ongoing diagnoses were XX XX sprain / strain with XX XX XX (XX) at XX-XX, XX XX, persistent XX since the date of injury, XX and XX unspecified, post-XX syndrome, and XX dysfunction / XX lesion of the XX XX.

On XX, XX. XX was seen in a follow-up by XX XX, XX for continued complaints of XX and XX XX pain. The pain in XX XX radiated into XX XX and XX XX down to both XX. XX continued to experience numbness and tingling in both XX. XX also continued to experience XX, XX, and XX XX. XX stated that the pain was worse since XX prior visit. XX rated XX pain at 5/10 at the time. The pain was described as continuous, burning, sharp, and needle-like. XX pain and symptoms interfered with XX, XX XX, XX, and recreational activities. Rest, treatment, and medication helped alleviate the pain. Repetitive movements, pushing / pulling, and lifting made XX pain worse. On examination, there was tenderness of the XX XX XX XX. Loss of joint motion was noted with motion palpation of the XX segments. Range of motion of the XX XX was restricted in all planes secondary to pain. Supine supported XX extension reproduced XX pain. Supine XX-hold against gravity reproduced XX pain. It was positive for XX, XX, XX XX, and XX XX. Motor strength testing was graded as weak to mildly weak (3-4/5) in the XX XX XX. XX. XX was diagnosed with XX XX sprain / strain with XX XX XX (XX) at XX-XX, XX XX, persistent XX since the date of injury, XX and XX unspecified, post-XX XX which was noncompensable, and XX dysfunction / XX lesion of the XX XX. It was noted that XX. XX had Contested Case Hearing (CCH) on XX. Per the decision, the compensable injury did not extend to and include the XX XX radiculopathy and post-XX XX. XX. XX recommended continuing XX sessions of XX therapy to address the ongoing flare-up and to assist in decreasing the pain, swelling, inflammation, and spasms and increasing the range of motion, strength, function, and flexibility. A follow-up with XX an orthopedic surgeon, was recommended as needed. XX. XX was allowed to return to work with restrictions. XX. XX returned to XX. XX on XX for a follow-up. XX continued to have complaints of pain in the XX and XX XX. The examination findings and diagnoses remained the same. XX. XX continued to recommended XX visits of XX therapy. XX referred XX. XX to XX. XX for pain management and recommended XX to XX hours of work with restrictions due to the ongoing examination findings and functional deficits that were not compatible with a safe return to full-duty work at the time. XX. XX was to follow-up with XX of orthopedic surgery as needed.

CT of the XX and x-rays of the XX XX were unremarkable.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 04/05/19

Magnetic resonance imaging (MRI) of the XX XX dated XX identified that there was no narrowing of the XX XX or XX XX at XX-XX. There was a broad-based XX XX most prominent to the XX midline by approximately XX mm, which impinged upon the anterior XX XX at XX-XX. The XX XX was patent. There was no narrowing of the XX XX or XX XX at XX-XX.

Treatment to date included medications (XX, XX, and XX), XX therapy, XX XX XX XX (XX) unit, work conditioning, XX therapy, and XX-XX transforaminal epidural steroid injection with 60% relief after XX week for XX, a non-compensable diagnosis per CCH D&O. It was noted that there was no treatment from XX until XX.

Per a Review Med Physician Advisor Determination and a Utilization Review dated XX, XX XX, XX denied the request for preauthorization of additional XX sessions of XX therapy, code XX-XX units, XX x XX weeks (XX sessions). Rationale" "There is no explanation as to what has caused the exacerbation and there is no comparison made to any previous clinical exam findings to support the request for additional XX at this juncture. In addition, the request does not comply with ODG criteria for additional XX following the completion of a XX.

Per an acknowledgement of Reconsideration / Appeal dated XX, XX of Review Med wrote to XX. XX informing that Review Med had received his reconsideration / appeal on XX for XX XX for Reconsideration for XX therapy XX sessions.

According to a Reconsideration Adverse Determination dated XX, XX, XX upheld the denial for the request of XX sessions of XX therapy consisting of therapeutic exercises (CPT XX). Rationale: "Recommend denial and non-certification of the services requested. The patient completed a chronic pain management program XX in XX after exhausting all lower levels of treatment including XX therapy. The ODG does not support dropping XX down into lower levels of treatment after completing XX. The patient has not required or has not been able to receive any care since that time. There is mention of an exacerbation, but there are no details outlining the nature or mechanism of the incident. The ODG would allow XX to XX XX sessions for a flare-up every XX to XX months for patients that have demonstrated a positive response in the past to XX therapy. This is mainly to keep the patient productive in the workforce. There is no documentation of this patient's current employment. There is only mention that XX cannot return XX to work safely without the requested services. There is no documentation that this claimant had a previous positive response to any XX therapy and XX required a XX program as a result. The request is mainly to get the claimant XX into the system again, as it is expressed, so that XX may receive an impairment rating. It is not medically necessary to receive any treatment prior to being evaluated for permanent impairment when all recommendations from the ODG have been exhausted. Therefore, it does not appear that the request for six XX therapy sessions would be consistent with the ODG or medically necessary at this time."

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 to the XX XX, XX x XX weeks, XX sessions.
XX - Therapeutic procedure, XX or more areas, each XX minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility is not recommended as medically necessary and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has undergone extensive treatment to date including a chronic pain management program. There is no documentation of significant and sustained improvement as a result of XX therapy completed to date. Given the chronicity of the injury and the extensive treatment completed to date, the patient should be well-versed in and encouraged to perform an independent, self-directed home exercise program. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Notice of Independent Review Decision

Case Number: XX Date of Notice: 04/05/19

- ☐ 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 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
- ☐ 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 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.