# Pure Resolutions LLC

## *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 4/17/2019 2:06:25 PM CST


# Pure Resolutions LLC

**An Independent Review Organization**
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**IRO REVIEWER REPORT**

**Date:** 4/17/2019 2:06:25 PM CST

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** XX therapy XX X week X XX weeks

**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 was injured on XX when XX had a XX on XX XX XX while XX XX with a XX. XX had some soreness, but later in the day, another XX was XX and XX XX in the XX XX, which significantly increased XX pain. XX was diagnosed with XX XX contusion / sprain. The ongoing diagnoses were contusion of XX XX, subsequent encounter (XX.XX); pain in XX XX (XX.XX); stiffness of XX XX, not elsewhere classified (XX.XX); and muscle weakness, generalized (XX.XX). On XX, XX. XX was evaluated by XX XX, X for follow-up on XX XX XX. XX had not had any relief of XX pain with medications and rest. XX was previously prescribed XX therapy, and XX was unable to go as XX was denied for XX therapy by XX XX. XX continued to have pain over the XX. The examination of the XX XX showed tenderness to palpation over the XX and XX XX line. Positive XX caused pain at the XX XX line. Positive XX XX test and XX of XX was noted. A request for XX therapy was renewed. XX was advised to continue with nonsteroidal anti-inflammatory medications. Per the Functional Capacity Evaluation report by XX XX, XX dated XX, XX. XX was referred to objectively quantify ongoing maximum voluntary XX capacity. XX complained of pain around the XX XX, and the XX XX feeling weak / unstable especially going up /

down stairs. As XX was becoming more active after the XX of XX XX XX XX prior, XX was noticing more pain. XX felt better in the morning with pain increasing as the day progressed. XX also felt better with stretching, decreasing walking, frequent position changes, and icing XX XX. The pain worsened by bending the XX XX, squatting, and with prolonged standing. Significant XX limitations were reported in activities such as work, and exercise (XX / XX). XX rated the pain as 2/10. The evaluation showed XX XX XX functional scale was 38%. The assessment of joint integrity revealed XX in the XX XX and lateral XX ligament (LCL) / anterior XX ligament (ACL) with significant XX XX. XX job required XX demand level (PDL) was light, and the safe recommended XX demand level (PDL) was medium. XX was performing at a level consistent with XX ongoing position as far as XX demand capacity (PDC); however, XX had persistent XX XX pain and limited tolerance for squatting, which was required by XX position. There were no signs of symptom magnification, and XX had a good validity profile. XX has not had formal XX therapy in the prior XX months. XX. XX felt that XX. XX would be an appropriate candidate for additional XX therapy at the time to address the weakness and instability noted in XX XX XX. If symptoms were not resolved, then additional diagnostic testing might be appropriate. Treatment to date consisted of medications (non-steroidal anti-inflammatory medications), and formal XX therapy (with significant benefits). Per a utilization review adverse determination letter dated XX, the request for XX visits of XX therapy was denied by XX. It was determined that the notes submitted for review included a pre-authorization request form and a prescription for XX therapy. There were no physician or XX therapy notes submitted displaying the need for the requested XX therapy. Also, XX. XX's injury was over XX XX old at the time. There was no indication as to whether or not XX had any previous XX therapy, and if so, how much. For these multiple reasons, non-certification of the request was recommended. A reconsideration review adverse determination letter dated XX by XX, indicated that the reconsideration request for XX therapy XX times per week for XX weeks (XX, XX, XX, XX, XX, XX) was non-certified. It was determined that XX. XX was XX in XX XX XX XX months prior. XX had formal XX therapy. XX had XX-XX and joint line symptoms. XX had not had an MRI, as XX was XX. The plan for therapy included multiple passive modalities including E-stim, massage therapy, and XX therapy. XX already had full XX range of motion and full strength. There was no XX instability. XX had XX symptoms with compression. There was no discussion regarding XX XX. Thus, the requested XX therapy for XX sessions was not medically necessary.

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

The ODG supports up to XX sessions of XX therapy for the treatment of XX strains to include therapeutic exercises, manual therapy, XX reeducation. The ODG does not support XX XX, XX devices, or ultrasound for the treatment of XX pain/strains. The documentation provided indicates that the injured worker has ongoing complaints of anterior XX XX pain which was previously treated with XX therapy. The number of visits and efficacy of treatment is unknown. A recent XX exam at XX therapy documented pain around the XX and limited tolerance with squatting. The injured worker is performing at an appropriate PDL. A XX exam documented tenderness over the XX and XX XX line and a positive XX as well as positive XX and XX of the XX. The writer has recommended XX additional sessions of XX therapy to include therapeutic exercises, manual therapy, neuromuscular education, XX XX, XX device, and ultrasound. Based on the documentation provided, the medical necessity for additional XX therapy cannot be established as it is unclear how many previous therapy sessions were attended and if they were efficacious. Additionally, the ODG does not support XX XX, ultrasound, or XX devices for the treatment of XX strains.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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**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

XX medicine treatment ; ODG XX Medicine Guidelines