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DATE NOTICE SENT TO ALL PARTIES: 4/3/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of XX sessions of post-operative XX therapy for the XX XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of prospective medical necessity of XX sessions of post-operative XX therapy for the XX XX.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant reported a pain in XX XX while at work XX a XX on XX. XX reports there was a pop. XX had extensive XX therapy without significant improvement. The reviewer reviewed the XX therapy notes from XX through XX. There was not significant improvement with therapy. On XX XX had a XX XX XX repair and continued post op therapy. Improvement is not noted. XX continued to complain of severe pain despite XX sessions of XX therapy.

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

Per the ODG, the following is recommended for
XX XX syndrome/Impingement syndrome:
Medical treatment: XX visits over XX weeks
Post-injection treatment: XX visits over XX XX
Post-surgical treatment, arthroscopic: XX visits over XX weeks
Post-surgical treatment, open: XX visits over XX weeks

The ODG guidelines do allow for XX therapy. It recommends that therapy demonstrate continued improvement with services and for fading frequency of treatments to allow the patient to begin HEP. The number of visits the patient has received thus far, exceeds the recommended visits allowed by the ODG. The ODG also would not allow for further XX (beyond the XX visits) when improvement is not being demonstrated: therefore, the requested XX is not medically necessary.

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)**