AccuReview

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[Date notice sent to all parties]: March 25, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX Therapy x XX for the XX XX

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

This physician is Board certified in Rehabilitation and XX Medicine Physician with over 18 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XX: Office Visit dictated by XX. CC: XX-year-old XX with new complaint of XX XX pain. Reported injury on XX when XX rolled XX XX at work, pain 4/10 described as continuous, aching, and shooting in nature. Pain increases with activity and decreases with rest. Previous treatment by ER physician and received XX for XX. XX has had x-ray and MRI. Medications: XX XX XX mg and XX XX mg. Patient is requesting second opinion for XX XX injury. Claimant reported XX off a XX XX, XX XX XX which was initially treated in a XX for XX-XX weeks and then underwent XX sessions of XX. XX had MRI diagnosing an impaction fracture of XX XX XX and therefore was placed back into the XX XX for another XX weeks, then transitioned into XX XX. XX reported not completing any XX sessions at this time. XX complains of diffuse pain about the XX but is not localized, worse with increased activity. PE: XX XX/XX Exam: Weakness noted to the posterior XX tendon and XX tendons. There is some mild swelling noted to the XX. There is some mild tenderness to palpation diffusely about the XX but does not localize to the XX joint and tenderness of palpation moderately to the ATFL. Impression: sprain of ligament of XX XX, initial encounter XX.XX. Plan: Claimant educated on common occurrence to have a contusion to the XX or XX XX with an XX sprain and that takes time to resolve. No mechanical symptoms noted, therefore persistent pain is XX failure to rehabilitate the XX after being in the XX for the additional XX weeks.

Discontinued use of XX/XX. XX exercises demonstrated. Rx given for strength, balance and proprioception. Discussed the importance of XX strengthening and issued a stabilizing XX XX today: XX up XX XX.

XX: Transcription dictated by XX. # of authorized visits used: XX. CC: pain XX XX 3/10, however continues to get sharp/shooting pain up the XX on XX XX that last for short periods. Onset is random. Evaluation: Fracture of XX, XX, XX closed, Sprain of XX XX. The claimant is consistent with the medical diagnosis referenced above. Impairment List: AROM, pain, muscle performance, joint mobility, gait overall progress, slower than expected, with continued limited ROM and strength and pain with prolonged standing/walking with these limitations. XX is not able to return to work, additional therapy is recommended to progress claimant to prior level of function without surgical intervention, per referring provider. Continue current treatment plan.

XX: UR performed by XX. Reason for denial: Claimant reported pain associated with an XX strain injury XX. The referral form noted that the claimant has already completed XX sessions of XX for the XX XX to date. XX, additional treatment was ordered. XX, the treating therapist noted that the claimant had completed eleven XX treatments to this date. Work status on XX, the claimant was given a XX hour per day standing and walking restriction, advised not to climb stairs and XX entirely. On XX, provider noted that the claimant sustained a fracture XX XX versus XX sprain, and the claimant was still using the XX. Work restrictions were imposed. The claimant had prior treatments of XX sessions, seemingly in-line with the XX session course recommended by ODG as part of medial treatment for fractures of the XX. ODG recommends that frequency of treatment should be appropriately tapered or faded over time as claimant transitions into HEP. Attending provider requested additional XX sessions of XX which is at odds with ODG recommendations to taper and fade the frequency over time. The XX findings on XX validate that the claimant was largely unimproved with prior treatment, suggesting XX failed to benefit in terms of functional improvement measures established in ODG with receipt of XX more sessions. It does not appear likely that the claimant could stand to gain from the continuation of XX, therefore, request is denied.

XX: Office Visit dictated by XX. CC: XX XX pain. Impression: sprain of other ligament of XX XX subsequent encounter. Plan: Claimant was not approved for XX. XX stated XX has been in XX and has had some improvement. Claimant does continue to however have significant weakness noted to the XX tendons and therefore requesting to continue to recommend XX as it is the most important part of recovery in an XX sprain. Wil appeal denial.

XX: UR performed by XX. Reason for denial: The history and documentation do not objectively support the request for an additional XX visits of XX currently. The ODG supports up to XX visits and the claimant has completed XX sessions and currently doing XX XX. XX has no pain. Outlier status has not been described. XX is overweight but has attended what should have been a reasonable number of XX visits and there is no clinical information that warrants the continuation of XX for an extended period. There is no evidence that the claimant is unable to complete XX rehab with an independent XX for additional strengthening. The medical necessity of this therapy has not clearly been demonstrated. Therefore, XX x XX for the XX XX is not medically necessary.

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

Previous adverse determination is upheld and agreed since the request exceeds ODG recommended number of visits and time frame for submitted diagnoses, and clinically after completion of XX visits over the last XX months since injury. There is no objective improvement in XX XX Range of Motion or strength, and there is documentation of instruction in and compliance with a Home Exercise Program. Therefore, after reviewing the medical records and documentation provided, medical necessity can not be confirmed and the request for XX Therapy x XX for the XX XX is denied.

Per ODG:

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)**