

## True Decisions Inc.

### *Notice of Independent Review Decision*

Case Number:

Date of Notice: 7/26/2019 10:12:20 AM CST

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**True Decisions Inc.**  
**An Independent Review Organization**  
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- INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
- Physical Therapy Note –X
  - Clinical Records –X
  - Peer Review Reports –X
  - Utilization Reviews –X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who sustained an injury on X. The biomechanics of the injury was not available in the medical records. X was diagnosed with unspecified X, subsequent encounter. X attended a X visit by X, PT on X. X reported significant improvement with X. X stated X continued to have discomfort over the X. X reported occasional X. The pain was rated at X. X was unable to participate fully in one or more community or life events to impairment associated with the ongoing injury. The examination findings included X surface to X, full range of motion with pain, X with X, and limited range of motion. It was noted that X had impairments in regard to X, X, pain, and X. The plan was to proceed with X, X. X was evaluated by X, DO on X for a follow-up of X pain, X pain, and X pain. X was taking medications as prescribed, and symptoms had not improved. X was not working, as there was no light duty available. On examination, X had persistent pain to the X. There was tenderness to palpation over the X. X had decreased X active range of motion due to X. X had some diffuse soreness to the X surfaces from X. There was tenderness over the X. Palpation showed X. The range of motion was limited. Dr. X recommended proceeding with X for the X and X. Dr. X allowed X to return to work with restrictions as of X. These included X. X was to take X. The treatment to date included X, X, and X (6 sessions

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with X improvement). Per a utilization determination letter dated X and peer review dated X, the request for additional X three times a week for two weeks / six sessions for the X was denied by X, MD as not medically necessary. Rationale: "The claimant is X and has been treated with X visits to date with X reported improvement. The medical record dated X indicates subjective reports of continued X pain. The objective findings include soreness to X, full range of motion with pain, tenderness to the X, and limited range of motion. X has not been working, as light duty is not available. The Official Disability Guidelines (ODG) guidelines typically recommend X, and X visits for the X. Furthermore, considering that the claimant is X, had X visits with continued pain and limitations, an additional four visits would be supported for treatment of the X. In that the claimant had X visits for the X, the additional X exceeds guideline recommendations and thus, not supported. However, according to Texas Law, I am unable to alter the prescription without speaking to the AP. As such, the request is not supported. Therefore, the request for Additional X, X Sessions for X is not medically necessary." Per an adverse determination letter dated X and peer review dated X, the prior denial was X by X, MD. Rationale: "The request in question, if approved in conjunction with the X previously completed treatments would, taken together, represent a total of X treatments, i.e. treatment in excess of X-session courses espoused in ODG's X Chapter for claimants with non-specific X pain and also represent treatment in excess of the X-session course espoused in ODG's X Chapter X Guidelines for claimants with non-specific X pain, i.e. the diagnoses reportedly presented here. ODG further stipulates that the frequency of treatment should be appropriately tapered or faded over time and notes in its X Chapter Functional Improvement Measures topic that functional improvement measures should be invoked repeatedly over the course of treatment so as to demonstrate progress in terms of return to functionally and so as to justify further use of ongoing treatment methods. Here, the request for continued treatment at a rate of thrice per week is at odds with the ODG's injunction to taper or fade the frequency over time. The claimant's failure to return to work and the fact that work restrictions remained in place as of the date in question, and the attending provider's failure to outline meaningful, material, and / or substantive

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improvements in function (if any) achieved through prior treatment, taken together, argue against the claimant's having derived requisite improvements in function needed to justify continuation of care. Therefore, the request is not medically necessary."

### **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 Additional X for the X, X sessions per week for two weeks, a total of X sessions is not recommended as medically necessary, and the previous denials are X. Per a utilization determination letter dated X and peer review dated X, the request for additional X a week for two weeks / six sessions for the X was denied by X, MD as not medically necessary. Rationale: "The claimant is X and has been treated with X visits to date with X reported improvement. The medical record dated X indicates subjective reports of continued X pain. The objective findings include soreness to X, full range of motion with pain, tenderness to the X, and limited range of motion. X has not been working, as light duty is not available. The Official Disability Guidelines (ODG) guidelines typically recommend X visits for X, and X visits for the X. Furthermore, considering that the claimant is X -injury, had X visits with continued pain and limitations, an additional X visits would be supported for treatment of the X. In that the claimant had X visits for the X, the additional X visits exceeds guideline recommendations and thus, not supported. However, according to Texas Law, I am unable to alter the prescription without speaking to the AP. As such, the request is not supported. Therefore, the request for Additional X, X is not medically necessary." Per an adverse determination letter dated X and peer review dated X, the prior denial was X by X, MD. Rationale: "The request in question, if approved in conjunction with the X previously completed treatments would, taken together, represent a total of X treatments, i.e. treatment in excess of X-session courses espoused in ODG's X Chapter for claimants with non-specific X pain and also represent treatment in

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excess of the X-session course espoused in ODG's X Chapter X Guidelines for claimants with non-specific X pain, i.e. the diagnoses reportedly presented here. ODG further stipulates that the frequency of treatment should be appropriately tapered or faded over time and notes in its X Chapter Functional Improvement Measures topic that functional improvement measures should be invoked repeatedly over the course of treatment so as to demonstrate progress in terms of return to functionally and so as to justify further use of ongoing treatment methods. Here, the request for continued treatment at a rate of thrice per week is at odds with the ODG's injunction to taper or fade the frequency over time. The claimant's failure to return to work and the fact that work restrictions remained in place as of the date in question, and the attending provider's failure to outline meaningful, material, and / or substantive improvements in function (if any) achieved through prior treatment, taken together, argue against the claimant's having derived requisite improvements in function needed to justify continuation of care. Therefore, the request is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is X. The request for X visits would exceed guideline recommendations. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. There are no contraindications to a X program documented.

Given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence-based guidelines and the decision is X.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

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

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ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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