IRO Express Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 2/8/2019 9:01:49 AM CST

IRO Express Inc.

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IRO REVIEWER REPORT

Date: 2/8/2019 9:01:49 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Individual XX X XX sessions

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

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 is a XX-year-old XX who was injured at work on XX. XX was XX the XX and XX on the XX and the XX. XX XX and XXX on XX XX and XX XX XX when trying to XX. XX had XX on the XX, worse on the XX. The diagnoses were other specified sprain of XX, subsequent encounter (XX); Unspecified fracture of unspecified XX, subsequent encounter for XX fracture with routine healing (XX); other XX, XX region (XX) and sprain of ligaments of XX, subsequent encounter (XX). On XX, XX. XX was evaluated by XX for swelling in the XX of the XX on the XX. XX had swelling in the XX. XX XX continued to bother XX quite a bit. XX also had XX and XX. XX experienced XX / XX pain. XX had a XX fracture on the XX. Examination of the XX showed swelling, tenderness, and guarding in the XX. Flexion and extension were decreased at 30 degrees and XX and radial deviation were decreased at 10 degrees. The XX deep tendon reflexes (at XX-XX) were diminished. Also, the XX deep tendon reflexes were diminished at the XX level and the

XX deep tendon reflex was diminished at the XX level. There was a positive XX test on the XX. The XX was percussed over the XX using a Taylor hammer. Radiating pain along the XX suggested XX pathology. The XX was percussed over the XX using a Taylor hammer. Radiating pain along the XX suggested XX pathology. There was XX XX Phalen's Test. Numbness was noted along the XX indicated XX syndrome while pain was nonspecific for other XX pathology. Also, there was XX Finkelstein's test on the XX. The pain indicated de XX XX. The XX extremity motor function was affected. XX flexion, extension, XX deviation and radial deviation muscle tests were XX at 4/5. A XX XX-XX was completed stating that XX. XX would be allowed to return to work as of XX with the restrictions, which were expected to last through XX. XX was restricted from lifting / carrying more than XX pounds. XX was advised to take breaks as needed. Per the Initial XX Medicine Assessment report dated XX, XX was evaluated by XX, for the assessment of XX XX status and to determine the relationship to the work accident. XX endorsed having XX that were XX and resulted in significant disruption of daily life. In addition, there were indications of XX, XX related to the XX or associated health concerns as manifested by XX having XX and XX XX about the seriousness of XX symptoms with excessive time and energy devoted to those symptoms or XX XX. Based on the information gathered through the initial interview and XX XX presentation and verbal report, it was determined that the work accident pain and ensuing functional limitations have caused XX XX in lifestyle, leading to XX. XX appeared to have been functioning independently prior to work injury dated XX. During the Client Motivation for Therapy Scale, XX obtained a score of XX in intrinsic XX, which involved taking part in an activity for the XX and XX inherent in engaging in the behavior itself. XX total score of 62 in the indicators of XX versus the score of 18 in indicators of external XX and XX clearly indicated that XX was a XX XX for individual XX. A XX Performance Evaluation was performed by XX on XX, where XX. XX showed evidence of pain and joint motion restrictions. XX had continued impairments with basic activities of daily living including: lifting, carrying, reaching and squeezing. XX had not lifted to the capacity required of XX job; and / or XX struggled with necessary XX XX necessary for working full-duty. The ongoing XX demand level (PDL) was sedentary light duty and required XX demand level was medium. An MRI of the XX dated XX revealed advanced healing, comminuted non-XX XX-XX fracture in the distal radial XX, grade I XX and XX of the extensor XX XX XX, the extensor XX XX XX and the extensor XX XX of the XX XX. There was a small XX joint effusion. X-ray of the XX XX dated XX revealed subacute comminuted non-displaced XX-XX fracture in the XX XX XX. X-rays of the XX XX showed mild degenerative XX and disc space narrowing at XX-XX and XX-XX levels. There was a reversal of the normal XX XX, likely from surrounding XX muscle spasm. X-rays of the XX XX demonstrated partial sacralization of the XX XX, mild degenerative XX at the XX-XX and XX-XX levels and moderate degenerative facet XX at the XX-XX level. Per a utilization review determination letter dated XX, the request for individual XX was denied. On XX, XX verified that XX. XX did not have symptoms of XX or XX. XX had XX XX and some XX XX. The Official Disability Guidelines recommend XX therapy if there had been no progress with XX therapy alone. XX. XX had not significant XX symptoms and that was unclear that there had been no progress with XX therapy. The request was not justified based on the information provided. Per a utilization review determination letter dated XX, the reconsideration request for XX was denied / non-certified. Rationale: “Official Disability Guidelines recommend XX treatment with patients who have chronic XX XX pain and the delayed recovery. Guidelines state patients should be screened for risk factors for a delayed recovery and initial therapy for those patients are at risk should have a XX modification approach with XX therapy. The guidelines state a referral for separate XX XX XX therapy (XX) can be considered if there is a lack of progress from XX therapy after XX weeks. An initial trial of XX sessions of XX can be appropriate. The guidelines state XX visits are generally separate from XX therapy and XX can be appropriate if XX therapy has been exhausted. The patient had a XX therapy visit but there was no indication as to how many sessions the patient had completed at this point nor was there an indication of the patient's actual progress or lack of. The XX therapist had documented that the patient was adhering to instructions and was progressing towards the treatment goals. The patient had a XX medicine assessment and it was determined that the patient had XX XX symptoms However, there was no indication of the patient's progress or lack of with prior XX therapy. The guidelines state that there must be documentation of the patient having tried and failed XX therapy. Given the above information, there is not enough medical evidence to warrant individual XX at this time Therefore, the request for Individual XX XX x XX weeks is not certified.” Treatment to date included medications (XX), XX therapy for

the XX (including therapeutic exercises, XX release, trigger point therapy, mobilization, XX techniques and XX techniques).

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 Individual XX XX sessions XX: XX, XX minutes with patient is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review determination letter dated XX, the request for individual XX was denied. On XX, XX verified that XX. XX did not have symptoms of XX or XX. XX had XX XX and some XX XX. The Official Disability Guidelines recommend XX XX therapy if there had been no progress with XX therapy alone. XX. XX had not significant XX symptoms and that was unclear that there had been no progress with XX therapy. The request was not justified based on the information provided. Per a utilization review determination letter dated XX, the reconsideration request for XX was denied / non-certified. Rationale: "Official Disability Guidelines recommend XX treatment with patients who have chronic XX XX pain and the delayed recovery. Guidelines state patients should be screened for risk factors for a delayed recovery and initial therapy for those patients are at risk should have a XX modification approach with XX therapy. The guidelines state a referral for separate XX XX XX therapy (XX) can be considered if there is a lack of progress from XX therapy after XX weeks. An initial trial of XX sessions of XX can be appropriate. The guidelines state XX visits are generally separate from XX therapy and XX can be appropriate if XX therapy has been exhausted. The patient had a XX therapy visit but there was no indication as to how many sessions the patient had completed at this point nor was there an indication of the patient's actual progress or lack of. The XX therapist had documented that the patient was adhering to instructions and was progressing towards the treatment goals. The patient had a XX medicine assessment and it was determined that the patient had XX XX symptoms However, there was no indication of the patient's progress or lack of with prior XX therapy. The guidelines state that there must be documentation of the patient having tried and failed XX therapy. Given the above information, there is not enough medical evidence to warrant individual XX at this time Therefore, the request for Individual XX XX x XX weeks is not certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient's initial diagnostic assessment indicates that the patient fails to present with significant XX symptoms. Beck XX Inventory score is XX and Beck XX Inventory score is XX. XX-W is 20 and XX-PA is 15 with the cut-off being 13. The goals of treatment are unclear. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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

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

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☒ 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

ODG XX Guidelines