US Decisions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX - therapy for the XX XX, XX times for XX weeks as an outpatient
XX - Therapeutic exercises and treatment for strength and movement recovery
XX - Manual therapy techniques, each XX minutes, requiring direct contact with physician or therapist
XX - Therapeutic activities that involve working directly with the provider
XX - Re-learning neuromuscular movement

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgeon

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

- ☐ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☑ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History

XX. XX XX is a XX-year-old XX who sustained an injury on XX. XX XX a XX, XX a XX of the XX XX. XX was diagnosed with XX of the XX XX, subsequent encounter (XX.XX).

Per a XX therapy note dated XX by XX / XX, XX. XX had completed XX therapy sessions, and XX was tolerating treatment fairly. XX had severe pain to the XX XX and XX, limiting progress with XX therapy. The passive range of motion was flexion to 25-30 degrees, extension to 25 degrees, radial deviation at 10%, and XX deviation at 20-30%. XX was able to make 50% of a fist. It was documented XX. XX would benefit from continued XX therapy to improve range of motion and strength. The treatment plan included continuation of XX therapy.

XX. XX was evaluated by XX on XX for follow-up of XX XX XX fracture and regional complex XX XX. XX was slowly improving, but XX continued to have some XX. On examination, XX was able to XX XX XX to within XX cm of the XX XX crease. XX had only about 10 degrees of supination and about 60 degrees of pronation. XX had about 10 degrees of XX and 10 degrees of XX flexion. XX recommended XX containing creams, a transcutaneous electrical nerve stimulation (TENS) unit, and additional XX therapy.

The treatment to date included medications (XX), activity modification, and XX XX therapy sessions.

Per a utilization review decision letter dated XX, the request for XX therapy for the XX XX, XX times a week for XX weeks as an outpatient between XX and XX was denied by XX. Rationale: "The official disability guidelines supports up to XX visits of XX therapy treatment after a XX XX fracture. This claimant has participated in XX visits and there are still significantly decreased range of motion deficits. Although progress was stated to be slower than expected, there have only been XX visits attended thus far. Accordingly, this request would be partially medically necessary for XX additional visits followed by an assessment of objective functional improvement. As a peer to peer could not be established to necessitate a partial certification, the request for XX XX Therapy evaluation and treatment to the XX XX, XX times a week for XX weeks is not medically necessary in its entirety."

Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: "According to the official disability guidelines, XX visits of XX weeks is recommended for a fracture of the XX. In this case, there was evidence the patient has completed XX XX therapy sessions with objective improvement with prior treatment. The claimant had evidence of continued functional deficits to the XX XX / XX with range of motion and strength. While additional therapy may be appropriate for this claimant, this request exceeds guideline recommendations for total duration of care, and there were no exceptional factors provided for review to support this request beyond guideline recommendations. Modification of treatment cannot be authorized given the jurisdiction of this case. Based on the above documentation, the requested additional XX therapy to the XX XX / XX XX times a week for XX weeks, as an outpatient is non-certified."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG supports up to XX visits of XX therapy for the medical management of XX XX fractures. The documentation invited indicates that the injured worker sustained a minimally displaced fracture of the XX radius on XX. A XX therapy progress note dated XX indicates that the patient has completed XX sessions of XX therapy and is tolerating treatment but has significant range of motion and strength deficits. The treating provider has indicated a diagnosis of complex regional XX and has recommended continued XX therapy with XX additional visits. Based on the documentation provided, the ODG would support up to XX visits of XX therapy for the injured worker. Given the ongoing functional deficits, an additional XX visits of XX therapy would be supported. Therefore, partial certification for XX additional visits is recommended for certification. Given the documentation available, partial request is considered medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain

Case Number: ***XX*** Date of Notice: 02/14/19

☐ 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 and Treatment Guidelines

ODG, 2019: XX, hand, wrist
Physical/ Occupational therapy
Recommended.
ODG Physical/Occupational Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved.
Fracture of XX bone (wrist):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of metacarpal bone (hand):
Medical treatment: 9 visits over 3 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of one or more phalanges of hand (fingers):
Minor, 8 visits over 5 weeks
Post-surgical treatment: Complicated, 16 visits over 10 weeks
Fracture of radius/ulna (XX):
Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 16 visits over 8 weeks

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

Notice of Independent Review Decision

Case Number: ***XX*** Date of Notice: 02/14/19

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.