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Information Provided to the IRO for Review

- Clinical Records – X
- Physical Therapy Notes –X
- Prospective Review – X
- Utilization Review – X
- Peer Review – X
- Diagnostic Data – X

Patient Clinical History (Summary)

X is a X-old-X who sustained an injury on X. X X X X causing pain and soreness to XX. X had some bruising of the XX was diagnosed with other injury of X.

X was evaluated by X, MD on X and X. On X, X presented for X complaints. X stated that overall the symptoms had decreased, but pain increased with activity, rated at X. There was an improvement X had decreased. On examination of the X, the diffuse tenderness had decreased. There was an improvement in X including X. The tenderness to palpation had resolved. X was on restricted duty at the time. Dr. X recommended continuing X for status-post surgery and decreased range of motion. On X, X continued to have pain when X X range of motion exercises. The pain was rated at X. The examination remained essentially unchanged.

X underwent X therapy evaluation by X, PTA /X, PT on X and X. On X, X had difficulty elevating above X degrees and X increase with active range

of motion. The plan was to proceed with X therapy for reducing impairments and improving functional performance. On X, X had decreased range of motion and strength. The pain was rated at X but increased to X at the extreme end of range of motion of the X. X activity restrictions included. X was working on restricted duty with no overhead tasks and no lifting with X.

X-ray report of the X dated on X was negative for fracture or dislocation. An MRI report of the X dated on X showed a large and complete X with marked retraction of the X, approximately X. There was similar X of the superior component of the X without the involvement of the X. There was a superior X through the X contact between the X and the undersurface of the X. A large X, with the extension of X throughout the X and X.

The treatment to date included medications (X), modified duty, a XX, a X, and X sessions of X therapy.

Per a utilization review decision letter dated X the request for X therapy for the X, three times per week for two weeks was denied by X, MD. Rationale: "Per Official Disability Guidelines (ODG), 'X syndrome /X: Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment, arthroscopic: 24 visits over 14 weeks. Post-surgical treatment, open 30 visits over 18 weeks' In this case, the claimant has complaints of X pain. A physical examination of the X revealed pain increases with activity. Diffuse tenderness. On X through X, the claimant received X therapy treatment with complaints of X pain. While there has been improvement in PT, the number of visits has exceeded guidelines and there is no rationale or contraindication that a self-directed home exercise program would not be sufficient to address any remaining

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deficits. Therefore, medical necessity has not been established for the requested continue physical therapy for the X3 x 2 weeks / 6 visits."

Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "There is no discussion of a daily home exercise program, no new therapy goals, and no change in the therapy program. There is no clear clinical rationale for the need to exceed Guideline. The patient has had 30 prior sessions with no documented reinjury. Based on the fact that the patient is five months post X arthroscopic X X and X on X, and the patient has already had excessive, 30 sessions of similar therapy with slow but consistent documented sustained functional improvement and without new hard clinical indications for need for additional 6 sessions. Therefore, the requested appeal for X 3 times a week over 2 weeks for the X 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 X, three times per week for two weeks X Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist, X Re-learning XX movement, X Therapeutic activities that involve working directly with the provider, X Therapeutic exercises and treatment for strength and movement recovery is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Additional supervised physical therapy 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. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Given the documentation available, the requested service(s) is considered not medically necessary.

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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
- ☐ 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
- ☐ 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)

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Appeal Information

You have the right 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.

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