Parker Healthcare Management Organization, Inc.

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IRO Cert#XX

DATE OF REVIEW: MARCH 21, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed XX additional sessions of postop XX Therapy for the XX XX XX X week for XX weeks (XX X XX, XX X XX, XX X XX), (XX X XX)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Uphold	(Agree)
☐ Overturned	(Disagree)
☐ Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX-year-old XX who was injured on XX, in a XX XX XX while XX an XX. The claimant was diagnosed with XX XX pain, stiffness of XX XX, muscle weakness, and abnormality of gate. It was noted that the claimant underwent surgical intervention to the XX XX on XX, which was described as an XX reconstruction procedure with XX postoperative XX therapy sessions. An evaluation on XX, documented a review about the claimant having had a reconstruction of the XX with drilling of an OCD lesion. The physical examination revealed normal range of motion and overall strength rated as 4-5/5. The claimant was noted to be improving and there was an injection performed to the XX nerve without complication that help significantly. There was no limitation with activity and was to tolerate weight-bearing.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The claimant has continued pain in the XX XX. According to the guidelines, XX therapy for postoperative XX sprain is recommended up to XX treatment sessions over XX weeks. The

claimant has already completed a total of XX postoperative XX therapy sessions. The request exceeds guideline recommendations. Also, there is no medical reason provided as to why the claimant would benefit from additional XX therapy and the claimant should be well-versed in active participation in a home exercise program at this point in recovery. There were no updated medical treatment notes provided for review as most recent evaluation was dated approximately XX months ago. The medical necessity for XX sessions of post op XX Therapy XX XX XX times a week for XX weeks (XX, XX, XX) has not been established. Therefore, the URA denial is upheld.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines XX and XX

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)