Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: resolutions.manager@cri-iro.com

Review Outcome

Description of the service or services in dispute:
XX Therapy XX times a week for XX weeks to the XX XX XX.

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified PM&R
Board Certified Pain Medicine

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 (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. XX reported that while at work XX sustained a serious injury to the XX XX XX and reported that XX severely XX XX XX XX and developed a XX XX of the XX-XX as well as fractures of the XX. XX was diagnosed with complex regional pain syndrome of the XX XX XX; complex regional pain syndrome, unspecified; muscle weakness (generalized), and pain in the XX XX XX.

On XX, XX evaluated XX. XX for a follow-up of XX XX pain and XX XX pain. XX. XX stated that the pain had started on XX after involving in a severe work-related injury. XX had undergone XX placement for the XX XX / XX fracture, as well as reduction of the XX XX fracture. Since the prior clinical encounter, XX denied any acute changes to the intensity, frequency, or quality of XX pain. The pain continued to be very bothersome and was affecting XX XX health, quality of life, functionality, and XX. XX had worsened XX and XX XX as a result of XX pain and had much difficulty XX XX. XX and XX helped “XX XX XX XX” and made the pain more tolerable; however, those medications were not effective as XX would like and XX continued to have pain when taking them as prescribed. The pain was located in the XX XX, which followed a non-dermatomal pattern. The pain was described as a severe burning, throbbing pain, which radiated slightly superiorly to the XX in an anterior fashion. The pain was rated as 8/10. The aggravating factors included movement, minimally bearing weight, and usage. Positive associated symptoms included decreased range of motion, which had mildly improved since the prior visit secondary to XX therapy. XX complained of swelling, decreased temperature, decreased sensation, and XX. Additionally, XX reported XX pain located in the XX XX region, which was well-localized without radiation. Examination of the XX XX showed severe XX and mottled appearance. There was severe XX to touch diffusely throughout, a marked decrease in temperature, limited flexion and extension, all consistent with severe, consistent with XX (XX) of the XX XX extremity. Increased XX was noted. XX XX examination revealed tenderness to palpation to the XX XX region. XX had pain with minimal extension and flexion.

X-rays of the XX XX and XX obtained on XX revealed XX XX fracture intramedullary nailing, and possible delayed union. X-rays of the XX XX revealed XX XX XX XX fracture, minimally displaced. X-rays of the XX XX and XX obtained on XX revealed XX XX fracture intramedullary nailing, possible delayed or nonunion developing.

The treatment to date consisted of XX placement for the XX XX / XX fracture and reduction of XX XX fracture on XX, XX XX sympathetic XX block at XX and XX (worsening pain and increased tingling sensation), XX, home exercise program (HEP), XX, postoperative XX therapy (minimal improvement) , inpatient stay, rehabilitation, XX XX, XX XX XX (XX), XX therapy XX (XX-XX), XX XX XX visit times XX approximately, medications [(XX – adverse effect), XX and XX (help and make the pain more tolerable), over-the-counter XX XX (XX - without relief) and restrictions.

Per a Physician Advisor Report dated XX, XX determined that the requested service of XX therapy XX times a week for XX weeks for XX XX XX was non-certified. Rationale: "A peer-to-peer discussion was not established. Regarding additional PT for the XX XX XX, the ODG XX and XX Chapter recommends up to XX visits of PT following open reduction internal fixation (ORIF) of XX and XX fractures and the ODG Pain Chapter recommends up to XX visits of PT for XX. This claimant had completed extensive rehabilitative therapy and continues with significant limitations. Since last evaluation on XX, the patient has improved XX range of motion (ROM) and strength. Additional PT appears reasonable given continued progress. However, the request for XX additional visits of PT appears excessive and is recommended for modification based on the ODG recommendations. Recommend XX additional sessions. Further such authorizations for PT should be based on subjective and objective evidence of improvement. Recommend modification to allow XX additional sessions limited to no more than XX modalities / procedural units of XX-XX minutes in total and exclude passive modalities such as E-stim and ultrasound in keeping with guideline recommendations. Recommend modification. Office called to discuss case but peer-to-peer contact was not established. However, XX legal statutes require successful peer-to-peer consensus agreement of proposed request modifications. As there has not been successful peer to peer, it is mandatory that the entire request must be non-certified. Recommend non-certification of the request for XX therapy, XX x XX weeks for the XX XX XX."

Per a Physician Advisor Report dated XX, XX determined that the requested service of XX therapy XX to XX times per week for XX to XX weeks was non-certified. Rationale: "Regarding the request for XX therapy XX-XX x XX-XX weeks for XX XX XX, it was noted that the patient had completed extensive rehabilitation therapy and continued with significant limitations. However, the request for additional visits of XX therapy is excessive. XX legal statutes require successful peer-to-peer consensus agreement of proposed request modifications. A peer to peer was not successful. As such, the request for XX therapy XX-XX x XX-XX weeks for the XX lower XX is non-certified."

Per a Physician Advisor Report dated XX, XX non-certified the request for XX therapy XX times a week for XX weeks. Rationale: "A peer-to-peer discussion was not unsuccessful despite calls to the doctor's office. ODG notes that the post-operative treatment for fracture of XX and XX is XX visits over XX weeks. ODG supports medical treatment for the reflex sympathetic XX as that which allows for fading of treatment frequency (from up to XX visits per week to XX week or less), plus active self-directed home PT, in XX visits over XX weeks. To justify ongoing treatment, even within these guidelines, patients should be formally assessed after a "XX-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the XX therapy). In this case, it is noted that the claimant underwent a XX XX / XX fracture and reduction of XX XX fracture on XX. The claimant was treated postoperatively with XX sessions of home health post-operative XX therapy, XX sessions of OT from XX-XX and approximately XX/XX sessions of PT from XX-XX. The claimant developed reflex sympathetic dystrophy in the XX XX extremity. As of XX, the claimant noted the pain level as 8/10. The XX extension lacks 5 degrees and flexion is 110 degrees. The muscle strength of the XX flexion is 3+/5 and extension is 4-/5. The claimant also has a restricted a range of motion in the XX XX with inversion to 10 degrees, eversion to 6 degrees, and dorsiflexion lacks 5 degrees. There is also noted muscle weakness in the XX XX and functional limitations as documented on the XX extremity functional scale score. As the claimant has not developed reflex sympathetic XX in the XX lower extremity and considering the ongoing clinical findings in the XX XX extremity, the medical necessity of XX sessions of PT is established to address the deficits and to improve functionality. Additional certification will require evidence of objective and functional progress and the need for skilled intervention. The provider has not been available to discuss a modified treatment plan and as the requested XX sessions of XX therapy are not supported and there has been no agreement to a modified treatment plan, the medical necessity of this request is not established. Recommend non-certification for XX therapy XXxXX weeks for the XX XX XX."

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 XX Therapy XX times a week for XX weeks to the XX XX XX is not recommended as medically necessary, and the previous denials are upheld. Additional supervised XX therapy visits would continue to

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. Office visit note dated XX indicates that the patient recently completed XX therapy with minimal improvement in the strength and range of motion of XX XX XX extremity. 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.

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 XX 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)

Appeal Information

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.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 03/18/19

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.