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IRO REVIEWER REPORT

Date: 2/28/2019 6:04:27 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Post operative therapy XX

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

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 XX is a XX-year-old XX who was diagnosed with XX, XX sprain, XX sprain and XX. On XX, XX was involved in a XX XX XX on XX way XX of XX due to XX XX. XX was XX from the XX by XX XX. XX was able to XX XX XX; however, XX then experienced pain in the XX and XX. XX. XX had a XX therapy initial evaluation on XX by XX XX, XX. XX was XX months status post XX surgery, which consisted of a multilevel fusion and decompression. XX pain was better but XX had XX XX it throughout the day due to XX XX and weakness. XX also had difficulty maintaining an XX XX and XX tended to maintain a forward XX XX and XX-XX XX of the XX XX. XX also suffered from XX XX pain and required pain medications. XX was using XX for neurological symptoms in XX XX and XX XX. XX had difficulty in activities of daily living and inability to work due to postsurgical weakness and XX fatigue. On examination, the XX Disability Index Questionnaire score was 30 indicating XX% disability. There was a XX XX surgical incision scar noted at XX-XX. The XX XX range of motion on forward XX was 50%, backward XX 25%, and XX side XX 50%. The XX side rotation at XX-XX was restricted. The gross muscle strength was measured as 4+/5 with XX flexion and 3+/5 with XX extension. The XX XX side bending strength was 3+/5 and XX XX rotation strength was 4/5. Treatment to date consisted of XX therapy and XX surgery. Per utilization review determination letter dated XX, the request for postoperative XX therapy to the XX XX was not certified. It was determined that XX. XX was well past the subacute healing phase postoperatively, XX-XX-XX-XX months prior. XX already had an unknown course of similar postoperative therapy and was 60% better at time of the XX examination. There were no new

hard clinical indications for need for overly XX times per weekly and excessive XX sessions of XX therapy. There was a lack of extenuating circumstances to exceed guideline, and XX was suitable for a home exercise program (HEP) alone for range of motion (ROM) and strengthening exercises. Given the clinical information submitted for the review and using the evidence-based, peer-reviewed guidelines referenced, the request was non-certified. Therefore, the proposed treatment consisting of postoperative XX therapy, XX, was not medically necessary. A utilization review request dated XX indicated that the reconsideration request for postoperative XX therapy to the XX XX was denied / non-certified. XX. XX was XX months status post XX surgery and had completed multiple sessions of XX therapy. The provider was requesting additional sessions. It was unclear how many prior XX therapy sessions were completed. A detailed, objective and comparative XX examination findings and documentation of XX. XX' objective response to prior XX therapy was not present and the medical necessity of the request was not established. Therefore, the proposed treatment consisting of postoperative XX therapy, XX, was not appropriate or medical necessary for the diagnosis and clinical findings. On XX XX, XX wrote a letter to appeal for reconsideration / approval of formal XX therapy sessions. He stated that XX. XX was under his care and had undergone major multilevel anterior / posterior XX XX surgery on XX. At XX XX-month postoperative visit dated XX, it was felt that XX was medically appropriate to participate in formal XX therapy to further strengthen XX XX XX and prevent exacerbation of pain. XX had begun to regress with pain and numbness to the XX XX extremity and XX would be benefited from XX therapy. XX had undergone multiple XX therapy sessions preoperatively, but had only had one evaluation postoperatively.

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 Postoperative XX therapy, XX, XX times per week for XX weeks is not recommended as medically necessary, and the previous denials are upheld. Per utilization review determination letter dated XX, the request for postoperative XX therapy to the XX XX was not certified. It was determined that XX. XX was well past the subacute healing phase postoperatively, XX months prior. XX already had an unknown course of similar postoperative therapy and was 60% better at time of the XX examination. There were no new hard clinical indications for need for overly XX times per weekly and excessive XX sessions of XX therapy. There was a lack of extenuating circumstances to exceed guideline, and XX was suitable for a home exercise program (HEP) alone for range of motion (ROM) and strengthening exercises. Given the clinical information submitted for the review and using the evidence-based, peer-reviewed guidelines referenced, the request was non-certified. Therefore, the proposed treatment consisting of postoperative XX therapy, XX, was not medically necessary. A utilization review request dated XX indicated that the reconsideration request for postoperative XX therapy to the XX XX was denied / non-certified. XX. XX was XX months status post XX surgery and had completed multiple sessions of XX therapy. The provider was requesting XX sessions. It was unclear how many prior XX therapy sessions were completed. A detailed, objective and comparative XX examination findings and documentation of XX. XX' objective response to prior XX therapy was not present and the medical necessity of the request was not established. Therefore, the proposed treatment consisting of postoperative XX therapy, XX, was not appropriate or medical necessary for the diagnosis and clinical findings. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records state that the patient has not completed any postoperative XX therapy. There is no clear rationale provided to explain the delay in treatment. The request for XX XX therapy visits is excessive and does not allow for adequate interim follow up to assess the patient's response to treatment and adjust the treatment plan accordingly.

Given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence based guidelines and the decision is upheld.

Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 2/28/2019 6:04:27 PM CST

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 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 & 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

XX and XX XX therapy (PT)